

CHANGES IN
THE PATTERN OF PUBLIC MENTAL HEALTH SERVICE PROVISION SINCE 1950
AND THEIR CAUSES

by

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ABSTRACT

State mental hospitals have been depopulated rapidly since 1950. This cannot be adequately understood as an implementation of the idealized concept of "deinstitutionalization," because adequate community services have not been developed to care for the large numbers of mentally ill persons now in the community. The change in the pattern of publicly provided mental health services is best understood as the response of essentially passive state governments to four forces: fiscal pressures, the availability of psychoactive drugs, changes in social policy at the federal level and court decisions. The importance of the deinstitutionalization concept has been to legitimate the changes occurring for these other reasons. The importance of the factors listed is demonstrated through an examination of the transformation of services in the state of Massachusetts.

The transformation of services has often had negative consequences for the mentally ill, as they have frequently been placed inappropriately in nursing homes or low-quality boarding homes. Insufficient outpatient services have been delivered, while the needs of discharged mental patients in the community have been inadequately monitored. The prevalent focus on the location in which the mentally ill are maintained is misleading, as it obscures more fundamental issues pertaining to the quality of care provided.

Thesis Supervisor: Donald A. Schon

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ACKNOWLEDGEMENTS

When I first began work on this thesis, one of my major interests was the effect of deinstitutionalization on state mental health employees. The changing pattern of public mental health service delivery turned out to be a rich enough topic in itself to warrant an entire thesis. I have therefore written a separate paper dealing with the labor relations issues. In the early stages of researching the thesis, however, I spoke with many people, mainly about how deinstitutionalization affects mental health workers, but also about deinstitutionalization in general. I am deeply indebted to the people who spent the time to talk with me, as they, more than anything, gave me the understanding of how mental health services are really changing. Although I will undoubtedly have forgotten people who were of great help to me, here is at least a partial list of people who I wish to thank: Joan Ackerman, Linda Chigas, Tom Coleman, Joe Correia, Pam Corradino, Ann Dadalt, Ann Day, Mike Dongarra, Agnes Durkin, Bob Fleischner, Randy Garber, Dick Goff, Lois Green, Leonard Gruenberg, Lee Hodnut, Michael Hogan, Stan Ikasalo, Debbie Jennings, William Jones, Joe Leavey, Alexander Leighton, Steve Lewis, Betty McGrath, Frank Mercier, Sara Mettes, David Moody, Gerry Morrissey, Ed Ruddy, Suzanne Sankar, Elizabeth Shafer, David Specht, Laura Spencer, Neil Stuart, Robert Tierney, Joan Tighe, Elaine Trudeau, Beverly Victory, Tom Wachtel, Tom Willemaine, Steve Wojtasinski. I also wish to thank all the people at Legal Services Institute, especially Michael Lipsky for his guidance while I was working there and for the advice he has given me as a member of my

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thesis committee. Similarly, I wish to thank Martin Rein, also a member of my committee, for his valuable suggestions. My greatest gratitude, however, goes to my supervisor, Donald Schon, who made the writing of this thesis a truly educational and rewarding experience.

I. INTRODUCTION

The location of a large class of mentally ill individuals has changed radically over the past thirty years. The number of people in state mental hospitals is now less than one-third as large as it was in 1955. The mentally ill persons traditionally housed in state hospitals are now found in a variety of settings. This change in the pattern of care is often referred to as "deinstitutionalization." The term "deinstitutionalization" has been used in several human service areas, including mental retardation services and youth services, to denote an ideology which advocates a shift away from institutionalization of clients in favor of the placement of clients in more normal living situations in the community. The term "normal" refers simply to decreasing the difference between the living situation of a client as compared to that of a member of the general population. The expression "in the community" is widely used to refer to any setting other than a traditional institution.

In the context of care for the mentally ill, deinstitutionalization can be viewed as a shift away from the use of the state mental hospital. Deinstitutionalization of the mentally ill is generally thought of as having three components: (1) the prevention of mental hospital admissions through the provision of alternate services in the community; (2) the release to the community of hospital patients who no longer require institutionalization; and (3) the provision of community mental health services to non-institutionalized persons.¹

While the change in the pattern of publicly provided mental health

care appears to have many of the characteristics embodied in the idea of deinstitutionalization, this paper argues that the pursuit of the therapeutic goal of deinstitutionalization has not been the only, nor even the primary, motivation for the change. Four other forces have been very important: (1) fiscal considerations of state governments; (2) changes in social policy; (3) technological changes in the treatment of the mentally ill; and (4) changes in the rights of the mentally ill, as defined by the courts. The primary role of the deinstitutionalization idea has been to legitimate changes motivated by these other forces. This process has had negative consequences for the mentally ill, because the changes -- guided as they have been by non-therapeutic concerns -- have often neglected the true needs of the mentally ill. Unfortunately, discussion of mental health services occurs all too often in terms of the ideology of deinstitutionalization, ignoring the more fundamental issues which determine the quality of public mental health care.

To observe the importance of each of the forces, it is helpful to observe their interplay in the arena where they come together -- mental health policy-making at the state level. The recent history of mental health policy in Massachusetts is therefore examined in detail. The case shows that concern for normalizing the living situation of the mentally ill has consistently been overwhelmed by the constraints, financial and otherwise, which set limits on the state's ability and motivation to pursue a major social reform.

The argument is developed over five chapters. Chapter II reviews the rise of institutional care for the mentally ill and the change in the role of the state hospital since 1950. Chapter III describes how the

aforementioned forces encouraged particular changes in the pattern of services provided. Chapter IV reviews the effects of the transformation of the mental health service system on the mentally ill. Chapter V examines in detail the transformation, its causes and its consequences for mentally ill individuals in Massachusetts. Finally, Chapter VI draws conclusions regarding the lessons to be learned from examining the process through which mental health policy has evolved.

Footnotes

¹Leona Bachrach, Deinstitutionalization: An Analytical Review and Sociological Perspective. (Rockville, Md.: National Institute of Mental Health, 1976), p. 1.

II. THE HISTORY OF INSTITUTIONAL CARE FOR THE MENTALLY ILL

Much of the recent history of public mental health service provision can be understood as an attempt to greatly reduce the number of persons institutionalized in state mental hospitals. To better understand this orientation, it is necessary to understand the origins of institutionalization of the mentally ill. The first section of this chapter reviews the development of mental hospitals, from their beginnings in the nineteenth century through the mid-twentieth century. The second section examines the recent changes in the role of state mental hospitals.

A. INSTITUTIONALIZATION OF THE MENTALLY ILL, 1800-1950

In the United States, mental hospitals date back to the beginning of the nineteenth century.

Before 1810, only a few eastern seaboard states had incorporated private institutions to care for the mentally ill, and Virginia alone had established a public asylum. All together they treated less than five hundred patients, most of whom came from well-to-do families. Few departures from colonial practices occurred in the first forty years after independence; the insane commonly languished in local jails or poorhouses or lived with family and friends.¹

Public attitudes were rapidly changing, however. Mental disease, once thought of as demonical possession or punishment for sins, was increasingly being viewed as an illness.² This contributed to a rapid growth in the number of public asylums:

in a dramatic transformation, state after state constructed asylums. Budding manufacturing centers like New York and Massachusetts erected institutions in the 1830s, and so did the agricultural states of Vermont and Tennessee, Ohio and Georgia. By 1850, almost every northeastern and midwestern legislature supported an asylum; by 1860, twenty-eight of the thirty-three states had public institutions for

the insane. Although not all of the mentally ill found a place within a hospital, and a good number of the chronic poor remained in almshouses and jails, the institutionalization of the insane became the standard procedure of the society during these years. A cult of asylum swept the country.³

Many of the early hospitals employed a treatment model called "moral treatment," which had been developed by Philippe Pinel in France.

Kindness was the fundamental ingredient in Pinel's therapeutic approach. Seeking to gain the patient's confidence and instill in him a sense of hope, he developed . . . "moral treatment" (which in contemporary psychiatry corresponds to milieu therapy). Milieu therapy involved the creation of a total therapeutic environment: social, psychological, physical. It assumed that insanity was a curable disease, given understanding, patience, kindness, and proper treatment. While moral treatment employed all of the known nonmedical techniques, it more specifically referred to therapeutic efforts which affected a patient's psychology.⁴

Moral treatment involved

open wards, occupational therapy, and pleasant surroundings in small institutions where the staff and especially the superintendent could know the patients personally and where kindness was the rule. The superintendent lived on the grounds, ate with the patients, and used his personality as his best therapeutic device. The use of standard drugs and treatment was lessened and the application of mechanical restraints was minimized or, in some cases, almost eliminated.⁵

At first, moral treatment was reasonably successful. An 1893 follow-up study of people who were patients at Worcester State Hospital during the 1830s and 1840s showed that 58% never had a relapse after discharge from the hospital.⁶ A number of factors, however, rapidly diminished the quality of care in the hospitals. Grob identifies four influences which put increasing pressure on hospitals:

First, the existence of a mental hospital meant that jails and almshouses were not the only places for confinement of insane persons. Families that had once been reluctant to send loved ones to substandard institutions were now more willing to consider the possibility of institutionalization. Second, the growing urbanization made it more and more difficult to care for the mentally ill in the community. Deviant behavior in densely populated areas not only posed greater problems than in rural areas, but it was also less likely to

be tolerated. Third, the establishment of a mental hospital increased social awareness of mental disease, and undoubtedly some of those who had been considered quaint or odd were now looked upon as insane. Finally, the rapid growth in population, which was partly associated with industrialization and partly with the tremendous increase in immigration from Ireland, was accompanied by a proportionate increase in the number of mentally ill persons.⁷

At the same time, recurring economic cycles of inflation and depression resulted in pressure on legislators to limit government expenditures. As poor immigrants began to fill the state hospitals, there was less and less willingness to provide the high level of care which characterized moral treatment.⁸ Some states built additional hospitals, but even so "overcrowding became endemic in state hospitals."⁹

It was common for state governments to charge local municipalities the costs of treating acute patients while assuming the costs of treating chronic patients. This had the effect of increasing the number of chronic patients in the care of hospitals. Chronic patients were unlikely to respond even to well-administered moral treatment and, thus, the recovery rates in state mental hospitals rapidly declined.¹⁰ This served to bolster the arguments of those who claimed that mental illness was incurable, many of them Social Darwinists who held that "the plight of the chronically insane person was caused by inferior genetic environment and not by social or environmental factors."¹¹ During the same period, a somatic view of psychiatric illness as a physical, not a psychosocial, disorder was rising. The implication was that moral treatment could not cure mental illness; rather, it was necessary to wait for medical science to discover the diseases which caused insanity.^{12,13,14}

State hospital superintendents realized that the effectiveness of institutionalization was rapidly decreasing, but nevertheless permitted

the proportion of chronic patients in their care to rise. This was because

[t]he superintendents feared that separate establishments for the chronic would rapidly degenerate into places as bad or even worse than the crudest almshouse. They may also have been wary about promoting a venture that would compete with their own for limited state funds. But they were also taking for themselves a function apart from cure, so as to base their task on less speculative and difficult grounds. Officials abandoned a high risk, high success operation for a minimum risk, minimum success one. Rather than rest the future of the asylum on the ability to rehabilitate the mentally ill, they assumed the failure-proof task of caring for the chronic.¹⁵

Thus, state hospitals ceased to function as therapeutic institutions and became custodial institutions. Eventually, "the group with the least prospect for rehabilitation took over the asylum."¹⁶

The middle class quickly became aware of the declining conditions in state hospitals. Private sanatoria sprang up in the Northeast and attracted increasingly large numbers of paying patients as state governments raised the fees charged those who could afford to pay for care in state hospitals.

By 1860, a two-class mental care system was in place -- the private and the public. State asylums were no longer viewed as treatment settings for all Americans, but as custodial facilities for the chronically insane poor, a group identified with despised ethnic groups who lacked political power.¹⁷

As early as the 1860s, the type of care provided in state hospitals was being criticized. Scull quotes the Massachusetts State Board of Charities Annual Report of 1867, which refers to

"the sight of so many patients in the prime of life sitting or lying about, moping idly and listlessly in the debilitating atmosphere of the wards, and sinking gradually into a torpor, like that of living corpses. . . ."¹⁸

As early as the nineteenth century, there were advocates of community care for the mentally ill, advocates of deinstitutionalization. Bemis,

writing in the Worcester State Hospital Annual Report of 1869, argues that no individual "should ever be confined to a lunatic hospital if he can have proper care and control out of it."¹⁹ In 1871, Maudsley wrote in his book, The Physiology and Pathology of the Mind:

"Instead of acting upon the general principle of confining the insane in asylums, and making the particular exceptions, we ought to act on the general principle of depriving no one of his liberty, and then making the necessary exceptions."²⁰

In spite of widespread criticism, state hospitals continued to be built and state mental health services remained entirely institutional.

As Scull points out, this is not entirely surprising, because

the very basis of the critics' case rested on a fundamental misreading of the public's concerns. The central element of their critique was that asylums were a therapeutic disaster. And one may grant that for those who still saw the cure as the primary issue, the fact that asylums were "more almshouses than hospitals" was a condemnation of the entire system. But to those who were already convinced of the value of a custodial operation (and most of the influential classes . . . , as well as the asylum superintendents, now felt this way), such complaints were simply an irrelevance.

For all the criticisms which could be made of them, asylums were still a convenient way of getting rid of inconvenient people. The community was used, by now, to disposing of the derelict and troublesome in this fashion, placing them where, as one physician put it, "they are for the most harmless because they are kept out of harm's way." . . . Asylums' earlier association with social reform gave a lingering humanitarian gloss to the huge, cheap, and avowedly custodial dumps where the refuse of the community was now collected together. Meanwhile, medical control of these institutions, and the rhetoric about the cure that went with that control, provided a further legitimation of the custodial warehousing of these, the most difficult and troublesome of the disreputable poor. Working people had little alternative but to make use of the asylum as a way of ridding themselves of what, in the context of nineteenth century working class existence, was undoubtedly an intolerable burden: the caring for their sick, aged, decrepit, or otherwise incapacitated relatives. From the upper classes' perspective, the existence of asylums to "treat" the insane at public expense could be invoked as a practical demonstration of their own humanitarian concern for the less fortunate.²¹

All public care for the mentally ill continued to be institutional

throughout the early part of the twentieth century. A former mental patient, Clifford Beers, drew some attention to the poor conditions in the hospitals with his book A Mind That Found Itself, published in 1908. Beers was also the driving force behind the National Committee for Mental Hygiene, founded in 1909. He

at first conceived of the National Committee as a vehicle for [thorough and long-term reform of mental hospitals], initially to consist of the abolition of mechanical restraints and the provision of comfortable, pleasant environments. . . . [T]he National Committee did effect some improvements -- partial eradication of the worst abuses and in a few instances the construction of new hospitals -- but these accomplishments were vitiated during the great depression of the 1930s.²²

The hospitals were under the control of superintendents reluctant to deal with the Committee; and the superintendents were themselves under the control of politicians who

all too frequently fired and hired hospital chiefs for reasons of politics or patronage and . . . as a rule were interested only in operating state institutions as cheaply as possible. To protect their jobs, superintendents tended to moderate their demands to fit the thinking of their employers. By the 20th century the resistance of hospital psychiatrists to large, overcrowded, understaffed, and underfinanced state institutions -- run like inefficient factories at the lowest possible cost -- was at best nominal; their role had been reduced to that of chief custodians who could not afford to provide treatment or permit staff members to try innovative practices.²³

It was not until World War II, when a large number of men were rejected for military service because of psychiatric disorders, that mental health policy became an issue of public concern. In 1946, the National Mental Health Act was passed. The act established a national mental health program, with the National Institute of Mental Health (NIMH) its primary creation. The leadership of NIMH was committed to community, as opposed to institutional, treatment of mental disorders. As the NIMH began to lobby for community mental health services, deinstitutionaliza-

tion finally became a popular cause. During the 1950s, under a variety of pressures, the use of state mental hospitals began to change.

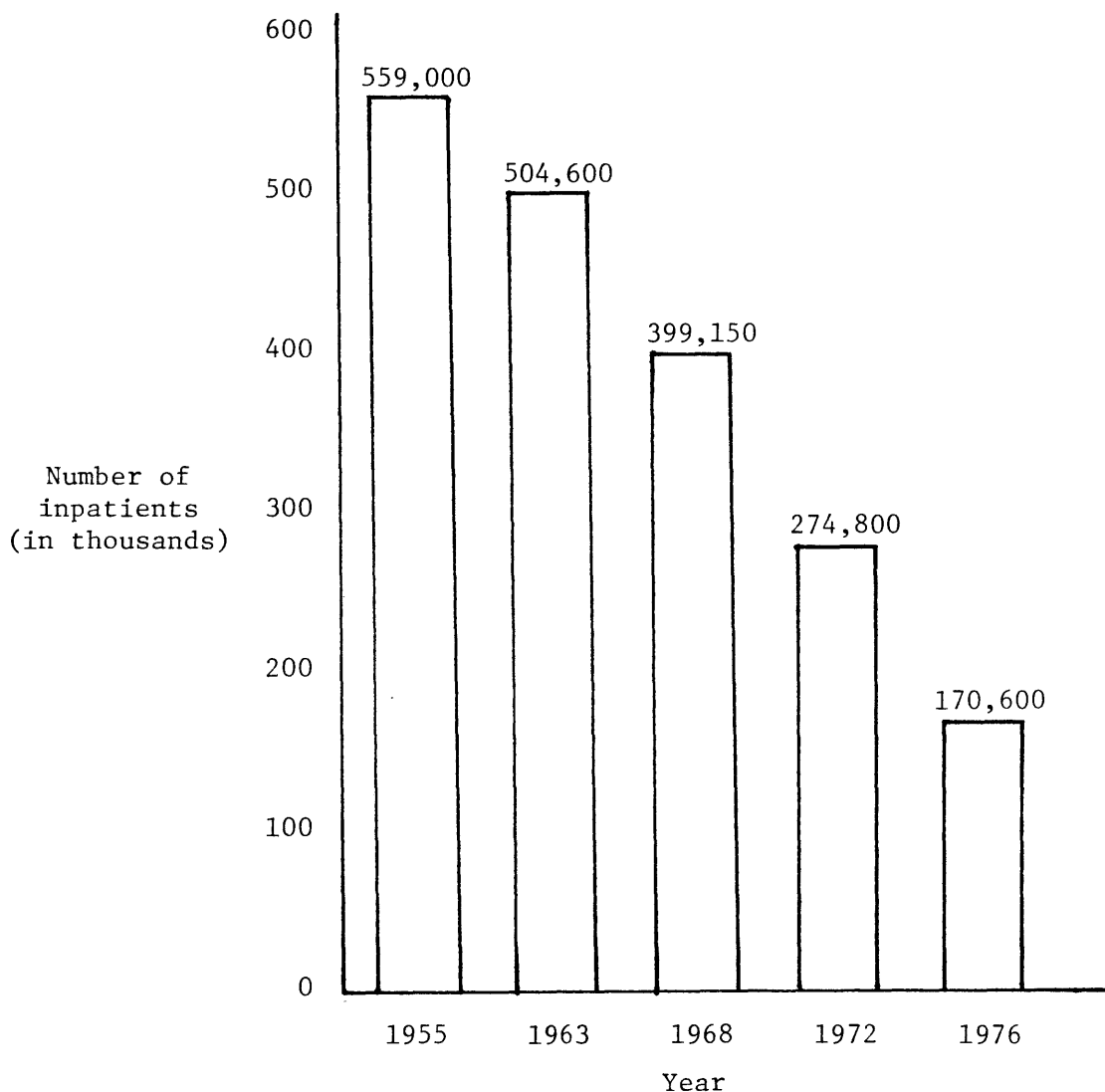
B. THE CHANGING ROLE OF STATE HOSPITALS SINCE 1950

After growing consistently for more than a century, the number of residents in state hospitals suddenly peaked and began to decline. This decline in the number of inpatients cared for at any given moment is the most conspicuous change in the role of the state hospital. As shown in Figure 1, the number of residents decreased from a maximum of 559,000 in 1955 to only 171,000 in 1976.

This census decline occurred primarily because hospitals began keeping residents for shorter lengths of time. As shown in Figure 2, the number of inpatient care episodes²⁴ declined at a much slower rate than did the inpatient census, decreasing from 819,000 in 1955 to 574,000 in 1977. This decrease was not due to a decrease in the demand for state hospital services. As Figure 3 shows, the number of first admissions to state hospitals continued to increase until 1969, reaching a peak of 164,000, up from 130,000 in 1962.

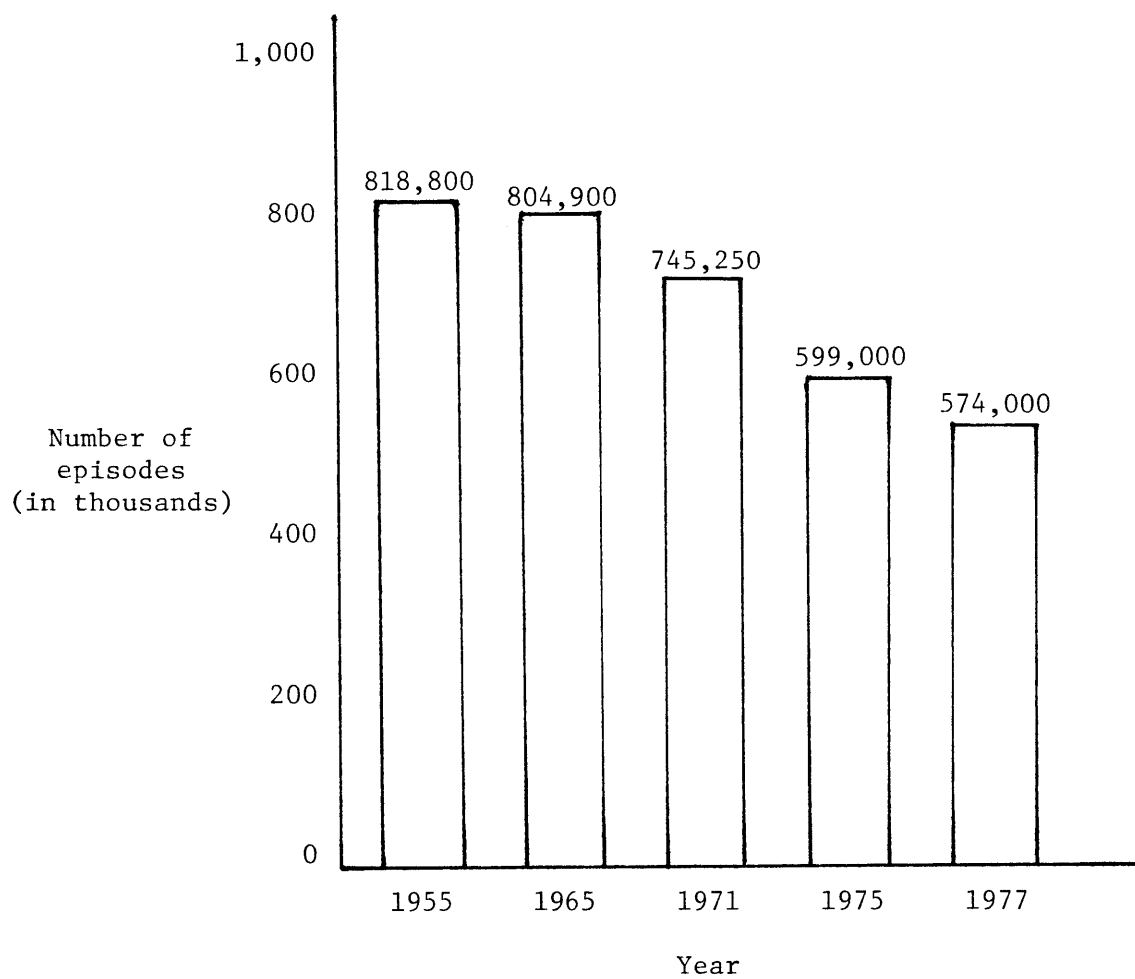
The average length-of-stay in a state hospital declined for both acute (short-stay) and chronic (long-stay) patients. It has been estimated that the average length-of-stay of acute patients has declined from eight months in 1954 to 1.5 months in 1971.²⁵ Most of the decrease in the resident census of institutions, however, is accounted for by the decrease in the number of chronic patients. Using as a measure of chronicity a current length-of-stay of 1.5 years or more, there were 426,000 chronic patients in state hospitals in 1960 (79% of the total). By 1970 this number had fallen to 254,000 (72% of the total).²⁶

Figure 1. Number of Residents in State and County Mental Hospitals,
United States, 1955-1976.



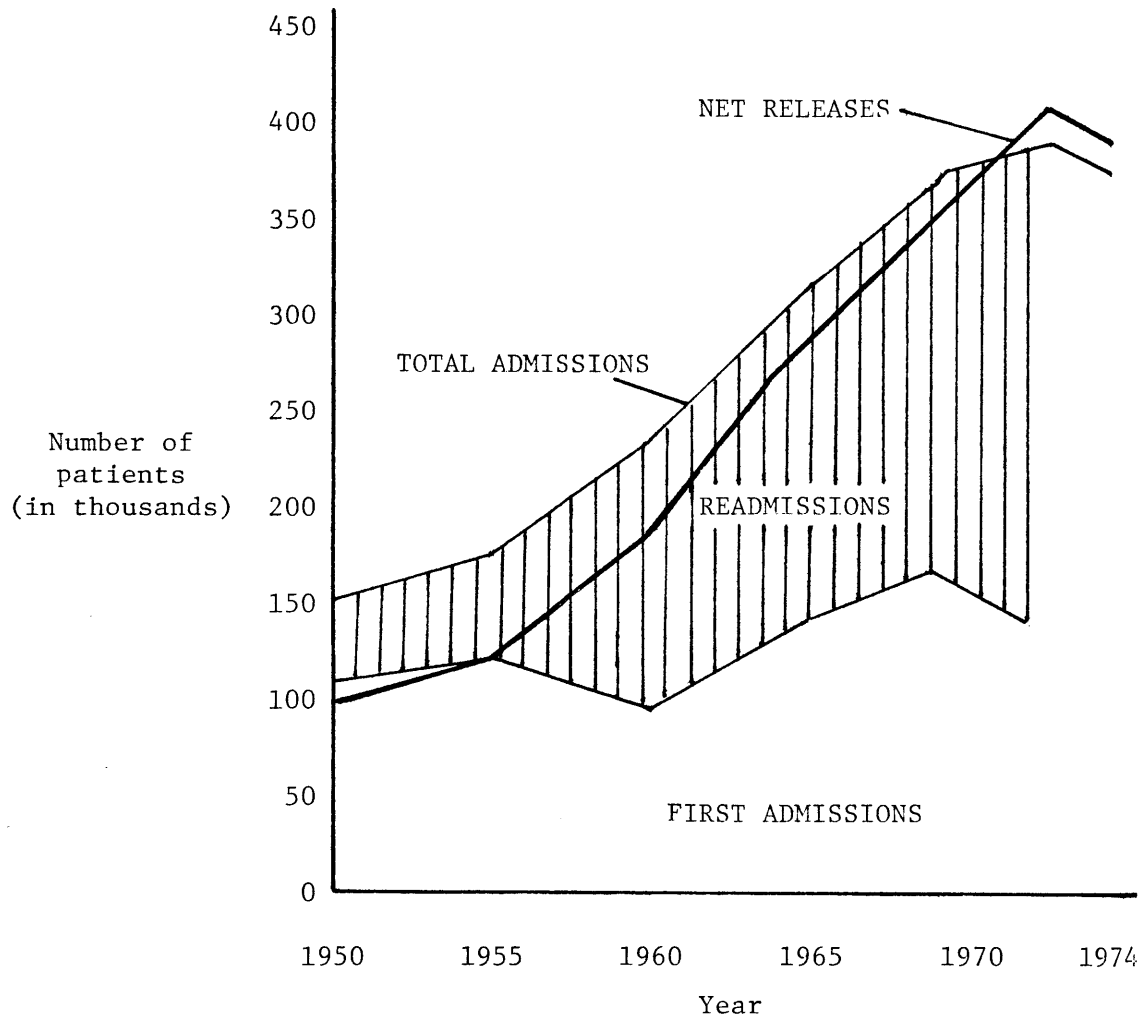
Sources: U.S. General Accounting Office, Returning The Mentally Disabled To The Community: Government Need To Do More (Washington, D.C.: Government Printing Office, 1977), p. 8; Laura Milazzo-Sayre, "Changes in the Age, Sex and Diagnostic Composition of the Resident Population of State and County Mental Hospitals, United States 1965-1975," Statistical Note 146 (Rockville, Md.: National Institute of Mental Health, Biometry Branch, 1978), p. 4; and Michael J. Witkin, "Provisional Patient Movement and Selective Administrative Data, Inpatient Services by State, United States 1976," Statistical Note No. 153 (Rockville, Md.: National Institute of Mental Health, 1979), p. 2.

Figure 2. Annual Number of Inpatient Care Episodes in State and County Mental Hospitals, United States, 1955-1977.



Source: Michael J. Witkin, "Trends in Patient Care Episodes in Mental Health Facilities, 1955-1977," Statistical Note No. 154 (Rockville, Md.: National Institute of Mental Health, Biometry Branch, 1980), p. 12

Figure 3. Number of First Admissions, Total Admissions and Net Releases,
State and County Mental Hospitals, United States, 1950-1974.



Source: Ellen L. Bassuk and Samuel Gerson, "Deinstitutionalization and Mental Health Services," Scientific American 238 (February 1978): p. 50.

The consequence of earlier release of patients has been a dramatic increase in the number of patients being readmitted to state hospitals after having been discharged. As Figure 3 shows, the proportion of admissions to state hospitals which are readmissions has increased from 25% in 1950 to 64% in 1972.

These statistics all suggest a profound transformation in the way state hospitals provide services to the mentally ill. They also raise two important questions. First, why was there such a dramatic change? The deficiencies of state hospitals had been recognized since the 1860s, but institutional censuses only began to decline in the 1950s. Yet the drop was so rapid that by 1976, after only twenty years, the inpatient population was about the same as it had been in 1910. Second, what became of the mentally ill when they were no longer cared for in state hospitals? Although state hospitals had a poor reputation for patient care, they did provide their patients with room and board and at least a semblance of therapeutic care. Who cared for the patients when they were discharged back into the community? The following two chapters take up these two questions in turn.

Footnotes

- ¹David J. Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (Boston: Little, Brown and Co., 1971), p. 130.
- ²Gerald N. Grob, "The State Mental Hospital in Mid-Nineteenth-Century America: A Social Analysis," American Psychologist 21 (June 1966): p. 511.
- ³Rothman, Discovery of the Asylum, p. 130.
- ⁴Grob, "State Mental Hospital in Mid-Nineteenth Century America," p. 511.
- ⁵Norman Dain, "From Colonial America to Bicentennial America: Two Centuries of Vicissitudes in the Institutional Care of Mental Patients," Bulletin of the New York Academy of Medicine 52 (December 1976): p. 1184.
- ⁶Joseph P. Morrissey and Howard H. Goldman, "The Ambiguous Legacy: 1856-1968," in The Enduring Asylum: Cycles of Institutional Reform at Worcester State Hospital, eds. Joseph P. Morrissey, Howard H. Goldman, and Lorraine V. Klerman (New York: Grune and Stratton, 1980), p. 62.
- ⁷Grob, "State Mental Hospital in Mid-Nineteenth Century America," pp. 515-516.
- ⁸Donald H. Williams, Elizabeth C. Bellis, and Sheila W. Wellington, "Deinstitutionalization and Social Policy: Historical Perspectives and Present Dilemmas," American Journal of Orthopsychiatry 50 (January 1980): pp. 56-57.
- ⁹Dain, "From Colonial America to Bicentennial America," p. 1185.
- ¹⁰Williams, Bellis, and Wellington, "Deinstitutionalization and Social Policy," pp. 56-57.
- ¹¹Williams, Bellis, and Wellington, "Deinstitutionalization and Social Policy," p. 58.
- ¹²Grob, "State Mental Hospital in Mid-Nineteenth Century America," p. 52.
- ¹³Dain, "From Colonial America to Bicentennial America," p. 1186.
- ¹⁴Gerald N. Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," Hastings Center Report, August 1977, pp. 36-38.
- ¹⁵Rothman, Discovery of the Asylum, p. 282.
- ¹⁶Rothman, Discovery of the Asylum, p. 282.

¹⁷Williams, Bellis, and Wellington, "Deinstitutionalization and Social Policy," p. 57.

¹⁸Quoted in Andrew T. Scull, Decarceration: Community Treatment and the Deviant -- A Radical View, (Englewood Cliffs, N.J.: Prentice-Hall, 1977), p. 108.

¹⁹Quoted in Scull, Decarceration, p. 111.

²⁰Quoted in Scull, Decarceration, pp. 111-112.

²¹Scull, Decarceration, pp. 128-129.

²²Dain, "From Colonial America to Bicentennial America," pp. 1188-1189.

²³Dain, "From Colonial America to Bicentennial America," p. 1191.

²⁴An "inpatient care episode" is defined as "the number of residents in inpatient facilities at the beginning of the year plus the total additions to these facilities during the year. Total additions during the year include new admissions, readmissions, and returns from long-term leave. It is, therefore, a duplicated count of persons." (Michael J. Witkin, "Trends in Patient Care Episodes in Mental Health Facilities 1955-1977," Statistical Note 154, Rockville, MD: National Institute of Mental Health, Biometry Branch, 1980, p. 6.)

²⁵Kenneth Minkoff, "A Map of Chronic Mental Patients," in The Chronic Mental Patient: Problems, Solutions and Recommendations for a Public Policy, ed. John A. Talbott (Washington, D.C.: American Psychiatric Association, 1978), p. 15.

²⁶Minkoff, "Map of Chronic Mental Patients," p. 15.

III. CAUSES OF THE TRANSFORMATION IN THE PATTERN OF PUBLIC MENTAL HEALTH SERVICE PROVISION

Throughout the period of depopulation of state institutions, the idea of deinstitutionalization of mental health care has been in good currency. It is therefore necessary to examine how the popularity of the idea has contributed to the transformation of mental health service provision. It seems unlikely, however, that the mere popularity of a reformist social idea could alone motivate a change as large as has occurred. One is therefore led to seek additional causes for the change. In seeking these causes, it is necessary to examine the situation of the state governments which bear the primary responsibility of caring for the mentally ill. Such an examination leads one to consider the forces which would compel state legislators and administrators to change their policies and the constraints which limit their options. The one consideration of state governments which is most immediately apparent is that of fiscal demands and constraints. One obvious motivation for depopulation of institutions is the need to limit expenditures in the face of increasing demands on state budgets. Another consideration is essentially technological. Whether or not state hospitals were functional in rehabilitating the mentally ill, they performed important social functions: they protected society from the mentally ill and protected the mentally ill from themselves. They also provided food and shelter for their residents. The freedom of states to release the mentally ill to the community has therefore been limited by the technology available to insure that these

needs continue to be satisfied outside the hospital. A third consideration is the context of national social policy in which state governments operate. Federal programs create incentives and disincentives to provide services in a given manner, while federal regulations create constraints on the freedom of state governments to pursue particular options. Finally, constraints are also created by the courts when their decisions restrict the freedom of state governments to treat the mentally ill in certain ways. All these considerations have had implications for the manner in which states have chosen to provide mental health services. In this chapter, the importance of each consideration will be examined.

A. PUBLIC AND PROFESSIONAL OPINION

The provision of mental health care in the community and not in institutions became a popular cause as a result of continuing awareness of the poor conditions in mental hospitals and professional lobbying in support of the development of community services. The general public was informed through the media of the problems with the hospitals:

In May 1947, Life published a bold photographic essay called "Bedlam USA"; it was later reprinted in the Reader's Digest under the title "The Shame of Our Mental Hospitals." A story in Woman's Home Companion, "What Is Wrong with Our Mental Hospitals?" became the subject of radio debates. Twentieth Century-Fox made a movie out of The Snake Pit, a best seller by Mary Jane Ward, a former mental patient. Throughout the country, many newspapers reported on mental institutions. The Kansas City Times, for example, ran a series of articles by Charles W. Graham, who recorded the deleterious effects of apathy on patients in Missouri and Kansas state hospitals. Patients, he noted, simply sat in rocking chairs, "hopelessly rocking away their hours, days, and months and years."¹

Within the psychiatric community, the American Journal of Psychiatry called the condition of mental hospitals "a disgrace to our civilization."²

The leadership of NIMH, predisposed as it was toward the development of community mental health services, used its influence to sponsor demonstration community programs (the first in Maryland in 1949) and to disseminate information about their success throughout the psychiatric community.³ As a result of the success of the war effort, the American public was optimistic about the prospects of addressing domestic ills and, consequently, the NIMH leaders found fertile ground for discussion of their ideas. Mental health was enough of a political issue that, in 1955, the Joint Commission on Mental Illness and Health was established in order to study how the nation's mental health could be improved. The Joint Commission produced a report, entitled Action for Mental Health, in 1961. The Commission envisioned a continuing role for state hospitals, but suggested that they be smaller, better financed and used only for intensive psychiatric treatment.⁴ The report also advocated the development of a national system of community mental health clinics.⁵

It was the latter recommendation which dominated the federal legislation which followed the Joint Commission's report. The NIMH leaders who participated in drafting the legislation were more concerned with the development of community services than with the improvement of state hospitals,⁶ while politicians were understandably reluctant to support the much maligned mental hospital. President Kennedy drew attention to the legislative initiative with his personal interest. The legislation provided funds for the construction of Community Mental Health Centers (CMHCs), which were to provide comprehensive inpatient and outpatient mental health services to catchment areas with 200,000 people or less. The popular sentiment in favor of the dismantling of the mental

hospital is in evidence in President Kennedy's statement when signing the bill into law:

"Under this legislation, custodial institutions will be replaced by therapeutic centers. It should be possible, within a decade or two, to reduce the number of persons in mental institutions by 50 percent or more."⁷

While the value of the legislation in decreasing the need for state hospitals is questionable, its passage was indicative of unprecedented public and professional support for the concept of development of community mental health services as an alternative to state hospitals. The idea of deinstitutionalization clearly did exist in the popular and professional imagination and cannot be ignored in a discussion of the reasons behind the transformation of mental health service provision. Other forces, however, were probably more important, in that they were more immediately felt by officials in state government.

B. FISCAL CONSIDERATIONS

In the 1950s, mental health services was a category of state government expenditures which appeared ready to explode in size. As Scull points out:

by the mid-1950s much of the physical plant of the mental hospital [system] . . . in . . . America, largely an inheritance from the nineteenth century, were rapidly approaching a degree of decay and decrepitude which would have made replacement mandatory. Moreover, annual admissions were already displaying a marked tendency to rise from one year to the next. . . . If the proportion of admissions becoming chronic long-stay cases had remained at or close to its historic levels, substantial new construction would obviously have been called for.⁸

Unable to limit the number of admissions to their hospitals, states could only keep down the size of their institutionalized population by releasing patients more quickly, which they began to do in the 1950s. The result

was that "mental hospitals were pictured as 'dying' institutions on which it was naturally foolish to spend any more by way of renovation -- and capital expenditure on them was reduced to a minimum."⁹

With the increasing awareness about mental illness in the general public, community resistance to the faster release of mental patients was less of an obstacle than it had been in the past. And, as will be seen, technological change removed another constraint in the way of depopulation of institutions, while national social policy increased the incentive to depopulate.

C. TECHNOLOGICAL CHANGE -- THE ROLE OF PSYCHOACTIVE DRUGS

One of the primary reasons that mentally ill persons have traditionally been institutionalized is to protect society, as well as the patients themselves, from their dangerous or bizarre behavior. States were limited in the number of patients they could release from hospitals by their inability to control the behavior of the patients outside the hospital. In the 1950s, however, psychoactive drugs were introduced. These had the property of being able to temporarily control some of this objectionable behavior. Where in earlier years patients who occasionally acted out psychotically needed to be institutionalized, it was now possible to discharge these patients with a supply of psychoactive drugs. Within the hospitals, it was possible to use the drugs as "chemical straitjackets," so that less time would be spent controlling patients and more time spent rehabilitating them. Much of the psychiatric community believes that depopulation of institutions was only possible with the introduction of these drugs. For example, Becker and Schulberg write that

The therapeutic efficacy of state hospitals was most improved, however, by the introduction in the 1950s of potent antipsychotic pharmacologic agents that, for the first time, gave psychiatrists effective weapons to battle schizophrenia and other psychotic illness. The ability of phenothiazines to control aggressive, destructive behavior and to reduce psychotic symptoms led to major changes in the state hospital's atmosphere. Optimism gradually replaced pessimism. Newly admitted patients were actively treated with phenothiazines, acute symptoms were relieved, and patients were frequently discharged within three to six weeks. Patients who were chronically ill also responded to these drugs, many showing a decrease in disruptive, aggressive behavior and others becoming less withdrawn and regressed. Rehabilitation programs were initiated to enhance work skills, foster resocialization, and bring the chronically institutionalized person to the point where community placement was possible.¹⁰

The growth in the use of the drugs was phenomenal. At the end of 1953, chlorpromazine had been tested on 104 psychiatric patients in the United States; thirteen months later it was being given to approximately two million patients.¹¹

Whether the drugs were so useful as to cause the remarkable depopulation of state hospitals is very doubtful. Scull cites a number of studies which found no correlation between the use of drugs and patient retention rates and points out that the average length-of-stay in state hospitals was already declining before the introduction of drugs.¹² Even if one assumes that the drugs are effective, there is no guarantee that a mentally ill person living independently in the community would use them. Nevertheless, it is clear that faith in the value of the drugs is widespread. At a minimum, the existence of psychoactive drugs provided the justification for the discharge of some hospital residents and decreased community resistance to the release of patients.

D. NATIONAL SOCIAL POLICY

The high cost of institutional care gave states an incentive to

discharge state hospital patients as quickly as possible, but states could not release the more severely ill patients without incurring substantial costs in order to provide for them in the community. The patients were, after all, often unable to support themselves. Many also required some form of custodial, if not medical, care. The rise of the largely federally financed welfare state decreased many of the costs to states of maintaining their mentally ill in the community. This occurred primarily through the expansion of income transfer programs and through increasing support for long-term health care.

1. Income Transfer Policy

Perhaps the most important change in national social policy was the growth of income transfer programs. That growth was characterized by increasing federal assumption of responsibility for income transfers. As Scull points out, the maintenance of the mentally ill in the community was unfeasible before the development of these programs:

Consider . . . what [a] . . . policy of managing the insane in the community would have involved. Keeping lunatics "on the outside" would have entailed making provision for relatively generous pension or welfare payments for their support. But at the least this would have raised the possibility that the living standards of families with an insane member would have been raised above those of the working class generally. Moreover, under this system, the insane alone would have been beneficiaries of something approximating a modern social welfare system, while their sane brethren were being subjected to the rigors of a Poor Law based on the principle of less eligibility. Such an approach would clearly have been administratively unworkable, especially given the labile nature of lunacy itself, and the consequent ever present possibility that given sufficient incentive (or rather desperation), the poorer classes would resort to feigning insanity.¹³

The situation changed with the passage of the Social Security Act in the 1930s and the gradual expansion of eligibility and benefits provided under the Act. With increasing numbers of cash recipients under the

various titles of the Act and the increasing adequacy of benefits, there were fewer fiscal dangers in providing for the mentally ill in the community. Indeed, the mentally ill became eligible to receive federal funds under the Totally and Permanently Disabled provisions of the Social Security Act, eventually subsumed by the Supplemental Security Income (SSI) program. Although many states supplemented SSI benefits, the cost to a state of maintaining a mentally disabled individual in the community on SSI benefits was far lower than the cost of institutionalization. A U.S. Senate committee concluded that, of the many factors that

come together to force the mentally impaired out of State hospitals into nursing homes, boarding homes, old hotels -- and sometimes into the streets [,] [t]he desire to save State dollars is clearly the most important . . . The enactment of the SSI program presents an opportunity of substituting Federal for State dollars. Assuming that a State is paying \$10,000 to \$20,000 a year per patient in its State hospitals and that the patient can be placed in boarding homes for \$1,884 a year (\$157 a month) in Federal SSI funds, the net impact on the State budget is a gain of thousands of dollars per patient per year!¹⁴

Rose shows in detail how the calculation looked for the government of New York state, where the state subsidizes federal SSI payments substantially, in 1974:

In New York, . . . the [average annual cost of caring for a person in a public mental hospital] was \$13,835. The cost of outpatient care in New York, or aftercare combined with outpatient care, during 1974 was \$531 per person per year of state mental health department funds. This fantastic saving was offset somewhat by the fact that a person discharged from the hospital was necessarily referred to SSI; this meant that residents of New York who were placed in adult homes received a monthly check of \$386.70 . . . The monthly cost to the state for each SSI recipient living in an adult home was \$219.00, while the federal share was \$167.70. On an annual basis, the cost to the state of New York for such a person consisted of \$2,628 of SSI funds (or less if the person was placed in a boarding home or hotel), plus \$531 of mental health funds. If an overestimate of \$1,500 is added for various services, the total still comes to just over \$4,600, some \$9,000 less than the annual per person cost of hospitalization.¹⁵

The SSI program not only encouraged the maintenance of the mentally ill outside state hospitals; the design of the program also discouraged the provision of any meaningful rehabilitative services to them in the community. Persons housed in state-operated programs, including community residences, were, before 1976, ineligible to receive SSI, which meant that states had to assume the entire cost of any such care which they provided. The states were free to place the mentally ill in privately-operated halfway houses. However, the amount of SSI payments was generally insufficient to purchase much beyond room and board. If states supplemented private halfway house operators with their own funds, the state funds were considered to be part of the income of the residents of the house, with the result that federal SSI payments were decreased. States therefore found it advantageous to house individuals in nursing homes instead of community residences. Although the total cost of the nursing home placement was higher, at least one-half was assumed by the federal government under the Medicaid program, with the result that the placement was often less costly to the state than a placement in a community residence.¹⁶

2. Health Policy

The Medicaid program was perhaps the most significant component of the other major change in national social policy, the federal initiative to improve the quality of and increase access to medical care. The Medicaid program, created in the 1965 amendments to the Social Security Act, reimbursed states 50% or more (depending on the income level in the state) of the costs of health care of persons receiving income transfers under other titles of the Act. As the numbers of people included under

these income transfer titles multiplied, so did the number of people receiving Medicaid benefits. By 1969, 12,060,000 persons were receiving Medicaid benefits; by 1978, 21,795,000.¹⁷ Disability was the basis of eligibility for benefits of 1,200,000 of these recipients in 1969 and of 2,900,000 of these recipients in 1978.¹⁸ Mental illness was the disabling condition of perhaps 19% of the disabled category.¹⁹

An important feature of the Medicaid program, and also of the Medicare program created at the same time, was its support of care in nursing homes. The federal government wished to see an expansion of the nursing home industry because, with a rapidly growing elderly population, the demand for hospital care was increasing rapidly. Nursing home care was seen as a less costly alternative for providing extended care to those (mostly elderly) people which required it.²⁰ With the newly available federal funds, the nursing home industry expanded: the number of nursing home beds more than doubled, from 510,180 to 1,174,800, between 1963 and 1973-74.²¹ By 1977, Medicaid alone financed one-half (50.8%) of all personal health care expenditures in nursing homes, although it paid for only 11.5% of the total amount of personal health care expenditures.²² It appears, then, that the existence of Medicaid was in large measure responsible for an increase in the number of nursing home beds available.

From the perspective of individual states, Medicaid had two important effects: (1) it greatly increased the number of nursing home beds available for placement of mentally ill persons; and (2) it paid for at least one-half of the cost of nursing home placement of the mentally ill who might otherwise have been maintained in state hospitals. As nursing home care for the mentally ill was far less expensive than state

hospital care, states had both the incentive and the supply of beds needed to permit the discharge of those hospital residents which would have been unable to live independently outside the hospital and which had no friends or family to care for them in the community.

The design of the Medicaid program was significant not only in its encouragement of nursing home care, but also in its lack of support for any of the other types of community care which might have been more appropriate for the care of some of the mentally ill. Medicaid was not available to persons housed in community residences, nor was it provided for such essentially non-medical (although therapeutic) services as sheltered workshops. Thus, Medicaid created an incentive not only to depopulate institutions, but also to place mentally ill persons in inappropriate community settings.

The Medicaid program gave states yet one more reason to depopulate their mental hospitals. The Medicaid program provided funds to care for some of the residents of state hospitals, but only if the hospitals met federal guidelines for quality of care. The prospect of 50% reimbursement of patient care costs was attractive to states, but the federal guidelines required greater per patient expenditures and limited the number of patients which could be housed in individual institutions. The effect was to encourage states to depopulate their institutions more rapidly so that they could comply with federal standards more easily.

3. Summary

This review of the effects on the mentally ill of changes in federal income transfer and health policy presents a picture of programs conceived with broad social goals in mind but which had inadvertant

effects on the mentally ill. The income transfer programs, conceived as part of an attack on poverty, removed the financial incentive for states to confine the mentally ill in institutions. The health programs, aimed at improving access to health care while keeping down per patient costs through the stimulation of nursing home development, encouraged states to place their mentally ill in nursing homes. The medically oriented design of the Medicaid program -- reflected both (1) in the inclusion of skilled nursing care but not psychosocial rehabilitation as reimbursable services and (2) in the promulgation of regulations mandating improvements in the standards of care in all reimbursable services, not excluding mental hospitals -- limited the range of community care options which were attractive to states while putting increased pressure on states to depopulate their mental hospitals.

E. COURT DECISIONS

The final major force affecting states' decisions to change their patterns of care for the mentally ill has been the judicial system. Court decisions have encouraged states to depopulate institutions by raising the standards of care required in, and therefore the costs of, state hospitals.

In Wyatt v. Stickney, the U.S. District Court held that patients could not be committed to Bryce State Hospital in Alabama if it provided only custodial, and not therapeutic, care:

When patients are . . . [involuntarily committed through noncriminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings] for treatment purposes they unquestionably have the constitutional right to receive such individual treatment as will give each of them a realistic opportunity

to be cured or to improve his or her mental condition. . . . The purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions. . . . According to the evidence in this case, the failure of Bryce Hospital to supply adequate treatment is due to a lack of operating funds. The failure to provide suitable and adequate treatment to the mentally ill cannot be justified by lack of staff or facilities. . . .

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There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment -- and adequate treatment from a medical standpoint -- to the several thousand patients who have been civilly committed to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process. [Emphasis in original.]²³

The Court imposed minimum standards of care which covered both the physical environment of and the level of services provided at the hospital. The decision not only increased patient care costs at Bryce, but also served notice to other hospitals that, unless they provide therapeutic care to their residents, they too might find themselves operating under the direction of a federal court.

In 1975, the U.S. Supreme Court ruled that confinement of a person in an institution "without more" -- presumably, something beyond custodial care -- is unconstitutional if that person is capable of living in a less restrictive setting. The decision in Donaldson v. O'Connor read, in part:

A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that the term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

. . . May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.

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. . . In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.²⁴

Donaldson v. O'Connor did not, however, consider the possibility of alternative treatment settings in the community, nor has any decision specified minimum standards of care for persons placed in community programs. Thus, the effect of federal court decisions has been to raise the cost of institutional care for the mentally ill without raising the cost of maintaining the mentally ill in the community.

A possible additional effect of court decisions has been to limit the ease with which persons can be committed to state hospitals. In 1974, in Lynch v. Baxley, the U.S. District Court overturned Alabama's commitment procedure and set out a far more rigorous procedure.²⁵ A few states have tightened their commitment procedures to make involuntary commitment more difficult, but it is not clear that this has been a response to the courts. The new procedures have given state hospitals increased power to limit their admissions, permitting depopulation of institutions beyond that achievable through discharge policies alone.

F. SUMMARY

To summarize, states have had a large financial incentive to depopulate their mental hospitals. The trend towards early discharge of patients which became apparent in the 1950s was a response to the overcrowding and poor physical condition of state hospitals. The financial incentives to depopulate institutions increased under the influence of federal programs and court decisions which required higher standards of care in institutions. Between 1967 and 1976, the daily maintenance expenditure per resident patient in state hospitals increased from \$8.84 to \$43.55.²⁶

At the same time, constraints limiting the freedom of states to maintain the mentally ill outside state hospitals either disappeared or became less important. The introduction in the 1950s of psychoactive drugs with the power of controlling symptoms of psychiatric illness made maintenance of the mentally ill in the community a more viable, or at least socially acceptable, proposition. The expansion of federal income transfer programs provided funds to support mentally ill persons in the community and so decreased the costs to states of community care. Federal health programs provided additional funds for community care and increased the supply of nursing home beds available to accommodate those who otherwise would have required state hospital care. The structure of federal programs, however, determined by broader social concerns, encouraged the placement of the mentally ill in nursing homes instead of in alternative community settings.

Throughout the period of depopulation of state hospitals, the ideology of deinstitutionalization has enjoyed some popularity, both

among mental health personnel and among the general public. This popularity is, however, best understood as a recognition of the problems with state hospital care. Advocacy of deinstitutionalization has therefore encouraged rapid depopulation. The fiscal incentives have nevertheless been sufficiently great that it seems likely that significant depopulation of state hospitals would have occurred even in the absence of a conspicuous deinstitutionalization movement.

Footnotes

¹Leland V. Bell, Treating the Mentally Ill: From Colonial Times to the Present (New York: Praeger, 1980), pp. 153-154.

²Bell, Treating the Mentally Ill, p. 154.

³Henry A. Foley, Community Mental Health Legislation: The Formative Process (Lexington, Mass.: Lexington Books, 1975), p. 35.

⁴Joint Commission on Mental Illness and Health, Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health (New York: John Wiley and Sons, 1961), p. 266-270.

⁵Joint Commission on Mental Illness and Health, Action for Mental Health, pp. 262-265.

⁶Foley, Community Mental Health Legislation, p. 38.

⁷Quoted in Foley, Community Mental Health Legislation, p. 83.

⁸Andrew T. Scull, Decarceration: Community Treatment and the Deviant -- A Radical View (Englewood Cliffs, N.J.: Prentice-Hall, 1977), p. 144.

⁹Scull, Decarceration, p. 144.

¹⁰Alvin Becker and Herbert C. Schulberg, "Phasing Out State Hospitals -- A Psychiatric Dilemma," New England Journal of Medicine 294 (January 29, 1976): p. 257.

¹¹Scull, Decarceration, p. 80.

¹²Scull, Decarceration, pp. 79-89.

¹³Scull, Decarceration, p. 130.

¹⁴U.S. Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry). 94th Cong., 2d sess., 1976, Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 7, p. 726.

¹⁵Stephen M. Rose, "Deciphering Deinstitutionalization: Complexities in Policy and Program Analysis," Milbank Memorial Fund Quarterly/Health and Society 57 (1979): pp. 429-460.

¹⁶U.S. General Accounting Office, Returning The Mentally Disabled To The Community: Government Needs To Do More (Washington, D.C.: Government Printing Office, 1977), pp. 124-132.

¹⁷ U.S. Department of Health, Education and Welfare, Health Care Financing Administration, Data on the Medicaid Program: Eligibility/Services/Expenditures (Washington, D.C.: Government Printing Office, 1979), p. 31.

¹⁸ U.S. Department of Health, Education, and Welfare, Data on the Medicaid Program, p. 32.

¹⁹ U.S. General Accounting Office, Returning The Mentally Disabled To The Community, p. 125.

²⁰ Sar Levitan and Richard Taggart, The Promise of Greatness (1976), p. 85.

²¹ Suresh Malhotra, John M. Wills and Michael A. Morrissey, Profits, Growth, and Reimbursement Systems in the Nursing Home Industry, (Baltimore: U.S. Health Care Financing Administration, 1981), p. 19.

²² U.S. Department of Health, Education and Welfare, Data on the Medicaid Program, p. 35.

²³ Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

²⁴ Donaldson v. O'Connor, 422 U.S. 563, 95 S. Ct. 2486 (1975).

²⁵ Council of State Governments, State Responsibilities to the Mentally Disabled (Lexington, Ky.: Council of State Governments, 1976), pp. 15-16.

²⁶ Michael J. Witkin, "Provisional Patient Movement and Selective Administrative Data, State and County Mental Hospitals, Inpatient Services by State: United States 1976," Statistical Note No. 153 (Rockville, Md.: National Institute of Mental Health, Biometry Branch, 1979), p. 6.

IV. CONSEQUENCES OF THE TRANSFORMATION IN THE PATTERN OF PUBLIC MENTAL HEALTH SERVICE PROVISION

As a result of the rapid depopulation of state hospitals, many more severely mentally ill people now live in the community than did in the past. This chapter examines the living situation of those mentally ill individuals in the community who, in the absence of a depopulation of state hospitals, would probably have been institutionalized.

Although many persons were perhaps inappropriately institutionalized prior to the 1950s, state hospitals nevertheless provided important services to much of the low-income mentally ill population. Most fundamentally, they provided shelter and basic services. The poor quality of both these aspects of state hospital care were widely criticized and, indeed, the foundation of the deinstitutionalization movement's popularity. The depopulation of institutions, however, was a response not so much to the deinstitutionalization movement as to the fiscal pressures bearing on state governments. It is not surprising, then, that the services provided to the mentally ill in the community have frequently been no better than those provided in state hospitals.

The first section of this chapter reviews the characteristics and needs of the class of people traditionally cared for in state hospitals. The second section examines where in the community they are housed, while the third section examines the kind of rehabilitative services they receive.

A. CHARACTERISTICS OF THE POPULATION

The population traditionally served by state hospitals has two major characteristics. First, its socioeconomic status is low. More affluent mentally ill persons have the financial resources, including insurance coverage, with which to purchase higher quality private psychiatric care. Second, its mental disorders are severe. Given the traditional negative image of care in state hospitals, institutionalization has long been viewed as a last resort. Where care has previously been provided by family, admission of an individual to a state hospital has therefore also represented the limits of the family's ability and/or willingness to care for the mentally ill person. Many hospitals residents have had no family to which they could turn for assistance upon release from the hospital.

The resident population of state hospitals can be subdivided into two types: acute and chronic. "Acute" refers to short-stay (typically, less than one year) patients, "chronic" to long-stay. Some acute patients come from relatively normal living situations, are admitted at a time of severe stress, and frequently return to a normal life. Others have more persistent problems and require frequent readmission to the hospital. They are frequently referred to as the "revolving-door" population. This latter group is more typically stable when outside the hospital and often has fewer family and friends to depend upon for social support.

Although there are many acute patients, their lengths of stay are sufficiently short that the bulk of state hospital residents at any one time are chronically ill. Using as a measure of chronicity a current hospital stay of 1.5 years or more, Minkoff¹ estimates that, in 1960, 79% (426,077) of state hospital residents were chronically ill and that in 1970,

72% (253,943) were chronically ill. It is the release of these individuals to the community which accounts for most of the decline in state hospital censuses. Minkoff estimates that, in 1974, the number of chronically ill hospital residents (using a one-year minimum length of stay) was declining at a net rate of about 18,000 per year. There were about 37,000 new chronic patients while 38,000 were discharged and 17,000 died. While most rehospitalization of discharged chronic patients is a frequent occurrence, Minkoff estimates that 90% of those chronic patients who have been discharged are outside the hospital at any given time. Although the death rate of discharged patients may be high, this nevertheless suggests that the large majority of the chronically ill persons historically cared for in state hospitals are now in the community.

The acutely and chronically ill groups both require the same basic services in the community: they need shelter, sustenance and sufficient mental health care to help prevent readmission. There are important differences, however. The chronic population, because of its long isolation from community life, can benefit greatly from a gradual transition to independent living, as is provided in facilities such as halfway houses. Acute patients, on the other hand, are more often able to return directly to a relatively normal living situation. The revolving-door acute population can benefit greatly from readily available outpatient services in the community, as these can help overcome psychiatric episodes before they become so severe as to require hospitalization. Unfortunately, the severely ill population is unlikely, because of the very nature of its ailments, to successfully seek out and find psychiatric services without active outreach and client tracking on the part of community service providers.

B. RESIDENTIAL LIVING ARRANGEMENT

1. Location in the Community

Advocates of deinstitutionalization do not expect the majority of hospital residents, especially chronic patients, to live independently upon release from the hospital. Rather, they envision a continuum of incrementally less restrictive settings, each of which provides enough rehabilitation to enable the patient to move on towards a more normal setting. It is understood that many of the more severely ill patients will only advance part of the way along the continuum. The goal, however, is to permit patients to live as normal a life as possible, to reach the limits of their capabilities and to prevent regression. In practice, however, the number of individuals released to such transitional facilities is negligible, because relatively few such facilities exist. Where they do exist, they seldom form a complete continuum of services, with the result that those facilities which do exist are often inappropriately used.

The settings in which discharged hospital residents are most commonly placed are: their family homes, nursing homes, board-and-care homes, and other independent living arrangements (e.g. apartments in old hotels, one-room apartments, etc.).² Table 1 shows the findings of a number of studies regarding the destination of discharged hospital residents. The Alabama study was conducted early in the process of institution depopulation and corresponds with other studies which show that traditionally over 65% of discharged patients have returned to their families. The Virginia study, conducted later in the process of depopulation, shows a smaller percentage (48%) returning to family. The 1975 New York City study shows only 23% returning to family. An earlier New York City study, conducted

Table 1. Percent of Discharged Mental Patients in Selected Community Settings, Various Studies.

Destination	Study					
	Alabama	Virginia (1974)	New York (1975)	Penn. (chronic 1960)	Calif. (chronic under 65 1972)	Mass. (chronic 65+ released en masse)
Transitional facility	5	--	--	--	4	8
Family	72	48	23	33	26	--**
Nursing homes	14	--	11	--	9	43
Board-and- care homes	--	10	--	22	49	19*
Other apartments	3	31	38	45	11	27**
Other or Unknown	6	11	28	--	1	--

* Rest homes

** 27% in "Other apartments" is made up of 8% in "cooperative apartments," 19% in "independent living." Some of the "independent living" were probably placed with families.

Source: Adapted from Kenneth Minkoff, "A Map of Chronic Mental Patients," in The Chronic Mental Patient in the Community: Problems, Solutions, and Recommendations for a Public Policy (Washington, D.C.: American Psychiatric Association, 1978), pp. 18, 28.

in the mid-1960's, showed two-thirds of discharges returning to families. The decrease in the number of discharges placed with families is probably a reflection of the fact that, as the depopulation of institutions has advanced, the patients remaining in institutions have been the difficult-to-place residents, many of them difficult-to-place because of their lack of meaningful ties in the community.

The percentage of hospital residents being discharged to family has always been lower for chronic than for acute patients. The 1960 Pennsylvania study of chronic discharges shows that only 33% were placed with families. The later (1972) California study shows the majority (60%) of non-elderly chronic discharges being placed in board-and-care homes and other similar settings. The Massachusetts data for a group of elderly chronic patients released en masse shows heavy reliance on nursing homes (43% of placements). This is indicative of the elderly population's lack of family supports; a Canadian study showed that only 9% of the elderly chronically ill return to families. In 1969, 40% of discharged elderly residents of state hospitals were placed in nursing homes. Of the chronically ill elderly, 58% of discharges were placed in nursing homes. Thus, a substantial number of hospital patients, especially chronic patients, have been placed in nursing and boarding homes. Among the chronically ill, the elderly have more often been placed in nursing homes, while the non-elderly have typically been placed in less intensive settings.

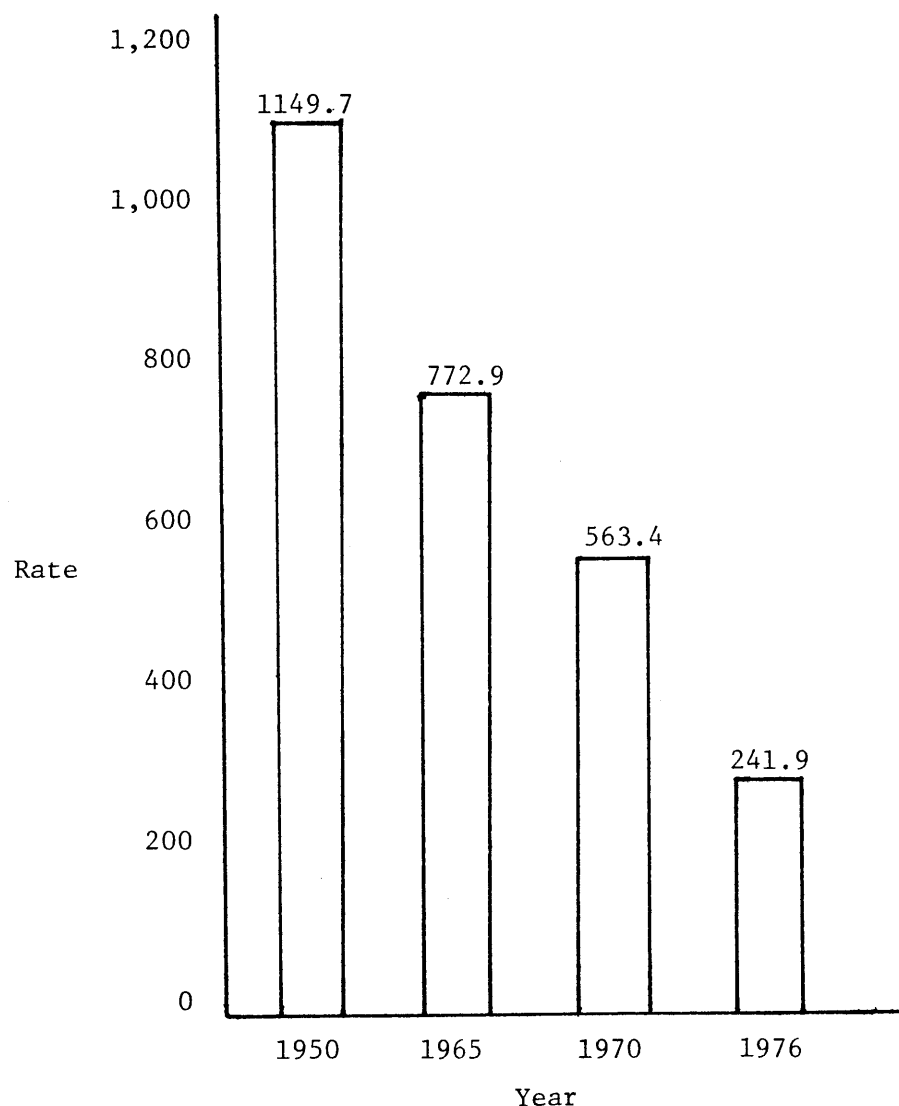
Examination of where hospital residents are placed upon discharge presents only part of the picture. With the increasing reluctance of hospitals to admit residents, it is also necessary to ask where in the community the mentally ill not being admitted to hospitals are being

maintained. The increasing reluctance of state hospitals to admit patients is most evident in the case of the elderly mentally ill. Between 1950 and 1975, the rate per 100,000 population of hospitalization of the elderly mentally ill declined from 1149.7 to 241.9 (see Figure 4). Between 1962 and 1975, the rate per 100,000 population of first admissions to state hospitals declined from 163.7 to 36.7 for the elderly. For all ages the comparable decline was only 70.6 to 57.1.³ In 1977, only 76,900 (5.9%) of 1,303,100 nursing home residents in the United States were known to have been admitted to their current setting directly from a state mental hospital.⁴ At the time of their last medical examination, however, 266,100 of the residents, or 20.4%, had a primary diagnosis of some form of mental disorder.⁵ The number of persons with chronic mental conditions was even higher: 324,700 (24.9%) suffered from chronic brain syndrome alone.⁶ Between 1963 and 1969, the total number of nursing home residents with mental disorders increased from 221,721 to 426,712. The majority of these were elderly: 187,675 in 1963, 367,586 in 1969. During the same period, the number of elderly residents in state hospitals declined from 148,842 to 111,420.⁷ The General Accounting Office concluded, in 1977, that

nursing homes are the largest single place of care for the mentally ill. They represent 29.3 percent, or \$4.2 billion, of the estimated total direct care costs for the mentally ill of \$14.5 billion in 1974. In contrast, State, county, and other public mental hospitals accounted for 22.8 percent of the total direct care costs.⁸

Finally, it should be noted that nursing homes have been used more frequently to care for the long-hospitalized chronically ill than for the revolving-door population. The revolving-door population tends to have infrequent, but severe, psychiatric episodes which nursing homes are

Figure 4. Resident patient rate per 100,000 population of persons 65 years of age or older, state and county mental hospitals, United States, 1950-1975.



Sources: Kenneth Minkoff, "A Map of Chronic Mental Patients," in The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy, ed. John A. Talbott (Washington, D.C.: American Psychiatric Association, 1978), p. 27; Laura Milazzo-Sayre, Changes in the Age, Sex and Diagnostic Composition of State and County Mental Hospitals, United States 1965-1975, "Statistical Note No. 146 (Rockville, Md.: National Institute of Mental Health, Biometry Branch, 1978), p. 4.

generally unwilling to deal with. Thus, where nursing home beds are in short supply -- as has been increasingly the case since the 1970s -- and nursing homes have the freedom to select their residents, they tend to choose to accept the more docile and predictable chronically ill. In addition, there is some evidence that the chronically ill placed in nursing homes tend to become concentrated in a relatively small number of homes which generally provide a low, essentially custodial, level of care.⁹ The revolving-door population is in turn pushed toward the even lower level of care provided in board-and-care homes and similar settings.

2. Characteristics of Community Settings

Of all the major settings in which the mentally ill are maintained in lieu of maintenance in state hospitals, none has the ideal features of the transitional community residences envisioned by advocates of deinstitutionalization. All of the settings have been criticized as inappropriate for the mentally ill. Some of the major criticisms will be reviewed here.

a. Family Care

Of the community settings in which the mentally ill are commonly maintained, the family home is perhaps the least objectionable. For many acute patients, severe psychiatric problems are temporary and therefore return to the family is entirely appropriate. For those with long-term problems, however, family care can produce widely different outcomes, depending on the characteristics of the family. In many cases, the attitude of the family towards its mentally ill member can lead to the social withdrawal of the patient and a consequent regression in his/her condition.¹⁰ This is all the more true because states provide few rehabilitative services to the mentally ill once they are placed in family homes. Moreover, the

presence of a mentally ill person in the household places a large burden on families, albeit a burden which many families readily accept.¹¹ Of particular concern is evidence that the presence of a mentally ill person in the home can create psychiatric and other problems among the formerly healthy members of the family. On the basis of his review of literature examining the effectiveness of care in the family, Arnhoff concludes that

there is considerable social cost in keeping the patient on home treatment, . . . with no clear-cut therapeutic advantage to the patient.¹²

b. Nursing Homes

It is widely argued that nursing home care for the mentally ill is no better than state hospital care. According to the General Accounting Office, a nursing home can be as institutional as a state hospital in terms of its "size, structured living environment and lack of privacy."¹³ In 1977, 57.7% of nursing home beds were in facilities of more than 50 beds, 26.9% in facilities with more than 100 beds.¹⁴ Regulated through Medicaid standards developed with the physically handicapped in mind, nursing homes provide custodial skilled nursing care, but provide virtually no therapeutic care which would permit mentally ill residents to improve their condition and so move on to a more independent living arrangement. Indeed, Medicaid regulations prohibit reimbursement for nursing homes where more than 50% of the residents have a primary diagnosis of mental illness. Under the influence of regulations and court decisions, the care currently provided to the mentally ill in state hospitals is probably more therapeutic than that in nursing homes.

Few of the mentally ill admitted to nursing homes ever progress to the point where they can be discharged to a less restrictive setting.

Patients admitted to nursing homes directly from a state hospital have a longer median length-of-stay in the nursing home than patients admitted from any other prior living arrangements -- 1,299 days as compared to an overall median of 597 days.¹⁵ In 1976, 34.7% of the 52,700 nursing home discharges with a primary diagnosis of chronic brain syndrome were deaths.¹⁶ Of the remainder, an indeterminate number were transferred to state hospitals or other nursing homes.

Because of the institutional character and lack of therapy of nursing homes, the reliance on nursing home placements to provide care for the mentally ill in the community has commonly been termed "reinstitutionalization" (or "transinstitutionalization") rather than "deinstitutionalization."

c. Board-and-Care Homes

Subject to even greater criticism than nursing home placements have been board-and-care home placements. Board-and-care homes provide little beyond a place to live. These homes are often unlicensed, but are heavily relied upon by state governments as a low-cost alternative for placement for the mentally ill when nursing home beds are unavailable. Reich and Siegel describe New York City's so-called proprietary homes as follows:

Proprietary homes are privately run group homes for adults, some as large as 285 beds. Clients residing in these facilities are expected to be self-sufficient, require a minimum amount of care, take their own medication and not disturb the other clients in any way. This type of home was clearly never intended to be a residence for the chronically mentally ill. Few of these homes have significant day programs or rehabilitative services, and few provide a systematic program of psychiatric care.

Several private entrepreneurs saw in the policies of the State Department of Mental Hygiene an opportunity for financial gain. Under

the facade of community service they refurbished unsuccessful old hotels and motels and arranged with the state hospitals to accept any patients the hospitals wished to discharge. The result is that many of these proprietary homes have become unsupervised state hospitals. Many of the patients were on high doses of tranquilizers, causing them to be apathetic, disinterested, and unable to function on any level. Young mental hospital dischargees became isolated in the homes because they were unable to relate to the average age of the other residents (over 65). Patients gathered in the lobby, gazing blankly into space, rocking back and forth, staring at a television set which has been turned off. If the clients deteriorated in the proprietary homes, they were often turned out on the street when the state hospitals did not readmit them.

Presently there are about 5,000 group proprietary home beds in New York City, of which about 50 per cent are occupied by mental hospital dischargees. In some homes as many as 85 per cent of the patients are from state hospitals, although the home is not specifically identified as being exclusively for the behalf of the mentally ill.¹⁷

A 1979 investigative report on the private proprietary homes by the Deputy Attorney General of New York State found pervasive

"unhealthy, unsanitary, and unsafe living conditions, poor nutrition, failure to provide even minimal services and recreational programs, deficiencies relating to medical care and the administration of medication and numerous violations of local building, fire and safety codes."¹⁸

The boarding homes have proliferated because, with little supervision from state authorities, operators can care for patients in substandard facilities and, consequently, profit considerably from the payments they receive to cover room and board. According to a Beacon Hill Update article, in Los Angeles

60 ex-mental patients "disappeared" one night from a boarding house. The residents had been "sold" to another residential hotel for \$83 apiece. The buyer made a good deal: His new tenants were worth up to \$300 a month in welfare checks.¹⁹

Indeed, state reimbursement schemes are often set up in such a way that boarding home operators have no incentive to provide good care. In Hawaii, for example,

state payments to former patients residing in licensed board and care homes are controlled by a point system in which each recipient is evaluated in terms of disability and the payment his boarding or care home operators are given is based upon this assessment. The more disabled or disturbed the patient, the more money the boarding home operator receives. . . . [T]he boarding home operators . . . in fact may receive a financial reward if the patient deteriorates.²⁰

One chain of boarding homes, called Beverly Enterprises,

started out in May, 1964, with three convalescent facilities. Today it owns 63 board-and-care homes and sanitariums in the United States, 38 of those in California; 12 general hospitals; and various land holdings. In 1972, its net revenue was \$79.5 million, up \$12 million from the previous year.²¹

d. The Homeless

Some mentally ill persons do not even have the good fortune to live in boarding homes. Because of the lack of low-cost housing and inadequate discharge planning at state hospitals, these people find no place to live at all and become "street people."²² Some find places to sleep and get occasional meals by coming to shelters, such as the Pine Street Inn in Boston and the Men's Shelter in the Bowery section of New York. On some nights the shelters have no room either and homeless people are turned away. According to Baxter and Hopper,

During the summer months, parks are resorted to -- even preferred to the other choices.²³

In the railroad station,

"At 11 P.M. the attendant goes off duty and women rise from separate niches and head for the bathroom. There they disrobe and wash their clothes and bodies. Depending on the length of the line at the hand dryers, they wait to dry their clothes, put them in their bags or wear them wet. One woman cleans and wraps her ulcerated legs with paper towels every night.

"The most assertive claim toilet cubicles, line them with newspapers for privacy and warmth and sleep curled round the basin. Once they are taken, the rest sleep along the walls, one on a box directly beneath the hand dryer which she pushed for warm air. One of the women regularly cleans the floors, sinks and toilets so that no traces of their uncustomary use remains.²⁴

There are only 3,200 beds in public shelters in New York City while there are 36,000 homeless persons.²⁵ At least 5,200 of the 47,000 chronically mentally disabled people living in New York outside hospitals are among the homeless.²⁶

The problem is aggravated by the resistance of the affluent to the placement of mentally ill persons in their communities. This, together with the general unavailability of low-cost housing, has in some cases led to the ghettoization of the mentally ill in run-down neighborhoods:

In some cases mental patients have been placed in the slums of our major cities in such numbers that their presence could scarcely remain unnoticed. This is the case in Uptown, an area of Chicago, where residents now speak of the "geriatric ghetto," a reference to the some 13,000 former mental patients that have been placed in this area of the city.²⁷

e. Summary

None of the major settings in which the mentally ill have been housed outside of state hospitals--neither family homes, nursing homes, nor board-and-care homes--provide the type of transitional community residential care envisioned as part of the idea of deinstitutionalization. State hospitals provide more therapeutic care than any of these alternatives. Board-and-care homes have even come under criticism for the poor living conditions they provide. A small but significant number of the mentally ill have nowhere to live at all. This situation casts serious doubt upon the value of maintenance in the community for the rehabilitation of the mentally ill. As Baxter and Hopper put it,

it has long been recognized that pathologies of place compound disorders of the mind. One study underway in Pittsburgh indicates that among ex-patients living in the community, the severity of roaches in the home is a better predictor of re-hospitalization than the severity of symptoms in the sensorium.²⁸

Nevertheless, placement in some community settings does increase the liberty of the mentally ill. Baxter and Hopper quote the New York State Commissioner of Mental Health:

"Hard though it may be to believe, however, many of the individuals living in [boarding homes] are there by choice and state a preference for remaining rather than returning to the hospital. If these individuals are prisoners, they are prisoners of poverty not of the mental health system. Were SSI benefits adequate. Were jobs really available. Were low income housing sufficient. Most of these individuals could live quite capably in community settings. While they may be living in circumstances far less than ideal, many of them prefer those circumstances to a hospital environment.²⁹

C. COMMUNITY MENTAL HEALTH SERVICES

The scarcity of therapeutic residential settings in the community would in itself not be so objectionable if other mental health services were available in the community. Acute patients would benefit from outpatient treatment, while the transition of chronic patients would be aided by programs providing them with day activities. Neither type of community service has been effectively provided to the low-income severely mentally ill. This is in part a reflection of the failure of the federal CMHC program to fulfill some of its stated objectives, but it is also indicative of a lack of alternative, state-provided mental health services in the community.

1. The Role of CMHCs

The construction of CMHCs was justified largely on the basis of their permitting the deinstitutionalization of the hospitalized mentally disabled. They were to provide the community outpatient care and short-term inpatient care which the discharged patients and possible future patients would require. CMHCs have not fulfilled their promise, however:

they were slow to be constructed and tend not to serve the types of people served by state hospitals. As Kirk and Therrien explain,

Although community mental health programs were established to supplant the traditional state mental hospital, both their ideology and their most common services are not directed at the needs of those who have traditionally resided in state psychiatric institutions. The ideology of community mental health has been primarily concerned with primary prevention, the importance of early diagnosis and treatment, consultation, social action, crisis intervention, short-term outpatient care, and time-limited, brief, inpatient care. Preferred target populations for such services are clearly normal populations who are at risk, persons with mild, acute, treatable disorders, who can be handled in office practice, or severely disordered persons suffering from their first psychiatric crisis. Community mental health programs do, of course, have services for other patient populations, specifically for patients with a long history of severe psychiatric disorder, but these programs are not meant to constitute the core of community mental health practice and are usually the least prestigious of the services offered, have the fewest and least trained staff, and are often viewed as undesirable but necessary services.³⁰

According to Chu and Trotter, the Community Mental Health Centers Act has simply helped to perpetuate a two-class system of health care, in which those who can afford to pay for private services get adequate care, while those who cannot are served by the system of state institutions. They contend that aspects of the CMHC regulations have in many instances been interpreted "as open invitation to psychiatrists to expand their private practices."³¹ For example, the Metropolitan Community Mental Health Center in Minneapolis, co-sponsored by two private hospitals and built with CMHC funds,

has nearly twice as many psychiatric beds as any other single hospital in the area. . . . The large majority of the patients . . . are referred to the center by private psychiatrists. The most recent statistics show that in the month of May, 1972, out of a total number of 168 patients admitted to the inpatient service, 100 were referred by private psychiatrists and an additional 5 by nonpsychiatric physicians. In contrast, 8 patients were referred by the county welfare department, 3 by the state employment agency, and 1 by the nearby Anoka State Hospital. There is no evidence that the center has established any working relationship with the state hospital, much less

had an impact on the admissions to the state hospital from its catchment area. The NIMH site-visit report state that the center has "no linkage with the state hospital for people from the service area." The site-visit further notes that many patients from the catchment area who initially contact the County General Hospital "are never offered alternative service at Metro, but are routinely transferred to Anoka." The report concludes, "This practice defeats the essential philosophic treatment concept of the Center program. Instead of changing the patient flow away from state hospitals and inpatient service, the emergency component supports the traditional status-quo of service delivery."

According to its director, it is the clear policy of the Metropolitan center to refuse to admit indigent patients for inpatient care. . . .

The service the Metropolitan Center most frequently provides to indigents is outpatient service. The extent of this "service" to the poor throughout most of the operation of the center is indicated by the statistic that as recently as February, 1970, the center was seeing a total of five outpatients per month! . . .

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According to NIMH regional office official Martin Keeley, the top staff at the Metropolitan Center were never interested in treating the indigent. Keeley stated that the psychiatrists "focused all their attention on the construction grant." Now that the building is finished, Keeley believes that the regional office has little leverage over what kind of services the center provides and to whom.³²

While most CMHCs have better records than the Metropolitan Center in providing services to their catchment area populations, the lack of sources of funding for the care of indigent patients has severely limited the potential of CMHCs to help those mentally ill unable to pay for their own care.

2. Other Community Mental Health Services

As CMHCs failed to satisfy the needs of the mentally ill at risk of hospitalization in the community, the responsibility for providing community mental health services fell to state mental health departments. States were, however, more interested in realizing the monetary savings of

depopulating institutions than in providing the necessary alternative community services. In New York, for example, discharge planning

is widely recognized to be "a joke," according to one member of the Quality of Care Commission for [New York state's] mental health system. Discharge planning, in most cases, amounts to giving the soon-to-be ex-patient the address of the Department of Social Services and a subway token to get there.³³

As state mental health agencies have failed to assume the responsibility of providing for the service needs of their clients in the community, these responsibilities have shifted to other agencies. For example, many of the discharged patients have rapidly become entangled in the criminal justice system. In Los Angeles County, in the year after the California legislature passed a law encouraging release of mental patients from state hospitals, "the number of arrests followed by incompetent-to-stand-trial pleas rose by 100%."³⁴ A Massachusetts Department of Mental Health study found in a survey of county corrections facilities that

one of every six admissions had at some time been in a state hospital, Community Mental Health Center, or community residence.³⁵

While the criminal justice system has been forced to assume some of the responsibility for discharged patients, the welfare system has been required to accept the primary burden. Welfare departments are generally responsible for the income security programs which provide the mentally ill with their incomes. Welfare agencies are also frequently responsible for providing services, including psychiatric care in the community and shelter. In the assessment of Gruenberg and Archer, the abandonment of the mentally ill is a consequence of the way in which responsibility has been transferred from mental health to public welfare agencies:

The deinstitutionalization policies leading to dramatic reductions in state mental health censuses of the 1970s can be seen as a rapid

acceleration of a trend to transfer financial responsibility for the chronically mentally ill patient from state mental health departments to the social welfare system. The present crisis of abandonment of the seriously mentally ill has arisen because no similar transfer of responsibility for their care and treatment has taken place. The erosion of state mental hospital responsibility has created a situation in which psychiatry's most helpless patients have no recourse against a general tendency of all medical services to reject their most unrewarding patients. While the seriously mentally ill are a visible problem causing much public concern, the tendency has been to advocate solutions which are somebody else's responsibility to execute. Social welfare departments are not equipped to provide the psychiatric attention that many of these patients need on a continuing basis.³⁶

Kirk and Therrien describe how, in Hawaii, the diffusion of responsibility between state agencies has worked to the detriment of ex-patients:

[A] source of conflict between the welfare and the psychiatric agencies in Hawaii is the "point system," by which the welfare department assesses the needs of former patients residing in boarding homes. . . . [T]he welfare department assesses each patient who resides in one of its licensed boarding homes; residents of unlicensed homes receive a substantially lower flat rate. The organizational conflict develops because the welfare department wants to keep expenditures as low as possible and tends to under-assess the disabilities of former psychiatric patients, while mental health personnel push for higher payments to boarding home operators, assuming that it will lead to better patient care. But . . . boarding home operators are given no incentive by either the welfare or the mental health department to help patients become more independent. Thus, the transfer of responsibility for patients from the state hospital to other community agencies has resulted not in greater continuity of care but rather in greater inter-organizational conflict.³⁷

The lack of willingness on the part of any agency to assume primary responsibility for those in need of services has been of tremendous consequence in the case of the mentally ill, because of the very nature of their disorders. In this respect, Whitmer's description of a typical ex-mental patient is especially telling:

[T]he discharge patient who is most in need of [outpatient psychiatric] services, but least able to secure them for himself, is the first patient to be lost. He is most likely the person who forgets his appointment time or forgets the person he is to see. Arriving at a clinic, he is easily discouraged by a receptionist who refers him on to a clinic closer to his neighborhood, or tells him that intake hours

are over, or that the physician is not in to prescribe medication on that day. If he finds his way to the waiting room, he usually does not have the minimum freedom from anxiety or unreasonable fears to sit with strangers. If he stays, he might become angry, paranoid and threatening to the staff. By his behavior, he indicates his need for treatment, but he is never the one to say, "I am in some distress, can you help?" Staff members often feel resentful and frightened. When he leaves, he is the patient who may never be seen again until admitted to an inpatient service.

He is also the person who never initiates outpatient contacts. He discontinues his medication, believing it to be the source of all his problems, citing as evidence his experience of uncomfortable side effects. He spends whatever he received from an income maintenance program in the first few days of the month, giving it to friends or spending it to self-medicate himself against anxiety with street drugs or alcohol. He will not live in any kind of residential care because the programs take too much of his income, threaten him with pernicious control over his long-disputed autonomy, and deprive him of the protection of social withdrawal allowed him in an isolated hotel room.³⁸

Thus, the lack of clear responsibility for provision of community services, combined with the expense and difficulty of serving the mentally ill in the community, has permitted the majority of the mentally ill in the community to "fall through the cracks" and receive no services at all until they require reinstitutionalization, either in a state mental health hospital or, increasingly often, in jail.

D. COMMUNITY VS. INSTITUTIONAL CARE

Professional opinion, for the most part, still favors community care over institutional care. The individual successes in well-run halfway houses are, however, overshadowed by the glaring inadequacy of community services. In concluding their comprehensive review of outcome studies on deinstitutionalization of psychiatric patients, Braun and his colleagues write that, with many qualifications,

the available studies of alternatives to [hospital] admission and of modifications of conventional hospitalization . . . describe results with respect to psychiatric status that are as good as, and in some

instances superior to, those observed with hospital management of control patients.³⁹

However, they found only two controlled studies of patients discharged after prolonged stays in mental hospitals, which led them to criticize the widespread release of such patients into the community:

The failure to have evaluated adequately the effect of discharging hundreds of thousands of chronically ill patients from large public mental hospitals has been a major defect in the conduct of public policy. As judged by the large numbers of anecdotal reports and newspaper essays on deinstitutionalization, the outcomes for hundreds of thousands of chronically ill mental hospital patients discharged to the community without the benefit of adequate services was likely worse than those expected with continued hospitalization.

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. . . The results of controlled studies, however favorable they might appear, can clearly not be used to justify the wholesale discharge of patients from large public mental hospitals to the community without provision of adequate care. That pattern of deinstitutionalization has been prevalent in many states. Regrettably, deinstitutionalization as it has been carried out on a large public scale may on balance have been harmful to long-term mental hospital patients.⁴⁰

Even this conclusion does not address a fundamental point: the focus on the location of care -- community as opposed to institution -- ignores a more basic question. What is the quality of care provided in a given setting, relative to the quality of care it is possible to provide in such a setting? The institutionalization of the mentally ill in private institutions has produced little public outrage, while nursing homes in the community are very much like state hospitals. As Arnhoff puts it:

the detrimental effects of institutionalization that are currently being expounded are not necessarily a function of institutionalization per se; they appear to exist in interaction with the quality of institution and the type of patient . . . Institutionalization . . . is not a unique characteristic of mental institutions but rather is a

possible and probable consequence in any setting characterized by neglect and depersonalization. The current policy of a large segment of the mental health professions, the National Institute of Mental Health, and the lay lobby organizations, that institutionalization is detrimental and the public institutions should be phased out over the shortest span of time possible, is based upon the logical fallacy that since bad hospitals are bad for patients, any hospitalization is bad for patients and should be avoided entirely or made as short as possible. Reinforcement for this position is provided by the most limited type of cost accounting and administrative statistics, from which it is fallaciously concluded that economies will be realized by such policies. Thus it is made to appear that humanitarian ends can be achieved at lower cost, an outcome that has obvious popular appeal. . . . [T]his policy will eventually lead to the need to rediscover the public institution . . . , since there unfortunately remain large numbers of chronic psychotics who are unable to exist outside an institutional setting.⁴¹

The inescapable reality is that good care for the mentally ill, whether in state hospitals or in alternate settings, would require much larger expenditures than have been made. The problem is described well by Borus, who writes that, in recent years,

mental-health professionals have learned much about the clinical care of the chronically mentally ill in the community. Innovative model programs . . . have demonstrated that with discriminate evaluation of the strengths and needs of the individual patient, adequate resources, designated responsibility for care, long-term provision of services, professional flexibility, and public support, many patients can lead reasonable lives outside institutions.

The limited ability to generalize and reproduce these model programs nationwide is in large part due to the public's enduring unwillingness to pay for high-quality care for the mentally ill. The custodial-level funding that politicians allocated to state hospitals over the years accurately reflected this limited public support; deinstitutionalization has shown that without sufficient resources, simply changing the locus of bad care will not create good care. Since provision of the many high-quality treatment alternatives that the severely ill require is an expensive proposition, it is even less likely to receive broad support in these times of fiscal restraint.⁴²

Footnotes

¹The statistics in this paragraph and the one following are adapted from Kenneth Minkoff, "A Map of Chronic Mental Patients," in The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy, ed. John A. Talbott (Washington, D.C.: American Psychiatric Association, 1978), pp. 15-16.

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⁷Richard W. Redick, "Patterns in the Use of Nursing Homes by the Aged Mentally Ill," Statistical Note No. 107 (Rockville, Md.: National Institute of Mental Health, Biometry Branch, 1974), p. 14.

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¹³U.S. General Accounting Office, Returning The Mentally Disabled To The Community, p. 16.

¹⁴U.S. National Center for Health Statistics, National Nursing Home Survey, p. 12.

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¹⁸Quoted in Ellen Baxter and Kim Hopper, "Pathologies of Place and Disorders of Mind: 'Community Living' for Ex-mental Patients in New York City," Health/PAC Bulletin 11 (March/April 1980): p. 10.

¹⁹"Deinstitutionalization in Massachusetts: Ex-patients Turn Up in Flophouses, Jail," Beacon Hill Update (July 10, 1981), p. 4.

²⁰Stuart A. Kirk and Mark E. Therrien, "Community Mental Health Myths and the Fate of Former Hospitalized Patients," Psychiatry 38 (August 1975): p. 215.

²¹Janet Chase, "Where Have All the Patients Gone?" Human Behavior 2 (October 1973): p. 17.

²²Baxter and Hooper, "Pathologies of Place and Disorders of Mind," p. 6.

²³Baxter and Hopper, "Pathologies of Place and Disorders of Mind," p. 7.

²⁴Ellen Baxter and Kim Hopper, Private Lives/Public Spaces: Homeless Adults on the Streets of New York City, quoted in David Bird, "Emergency Shelter Plan Sought for the Homeless: Help Is Urged for 36,000 Homeless in City's Streets," New York Times, March 8, 1981, p. 44.

²⁵Baxter and Hopper, quoted in Bird, "Emergency Shelter Plan Sought for the Homeless," p. 1.

²⁶Baxter and Hopper, "Pathologies of Place and Disorders of Mind," p. 6.

²⁷U.S. Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry). 94th Cong., 2d sess., 1976, Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 7, p. 752.

- ²⁸Baxter and Hopper, "Pathologies of Place and Disorders of Mind," p. 21.
- ²⁹Quoted in Baxter and Hopper, "Pathologies of Place and Disorders of Mind," p. 21.
- ³⁰Kirk and Therrien, "Community Mental Health Myths," p. 210.
- ³¹Franklin D. Chu and Sharland Trotter, The Madness Establishment: Ralph Nader's Study Group Report on the National Institute of Mental Health (New York: Grossman, 1974), p. 89.
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- ³³Baxter and Hopper, "Pathologies of Place and Disorders of Mind," p. 6.
- ³⁴Gary E. Whitmer, "From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill," American Journal of Orthopsychiatry 50 (January 1980): pp. 65-75.
- ³⁵"Deinstitutionalization in Massachusetts," p. 4.
- ³⁶Ernest M. Gruenberg and Janet Archer, "Abandonment of Responsibility for the Seriously Mentally Ill," Milbank Memorial Fund Quarterly/Health and Society 57 (1979): p. 33.
- ³⁷Kirk and Therrien, "Community Mental Health Myths," p. 216.
- ³⁸Whitmer, "From Hospitals to Jails," pp. 67-68.
- ³⁹Peter Braun et al., "Overview: Deinstitutionalization of Psychiatric Patients, a Critical Review of Outcome Studies," American Journal of Psychiatry 138 (June 1981), p. 748.
- ⁴⁰Braun et al., "Overview: Deinstitutionalization of Psychiatric Patients," pp. 747-748.
- ⁴¹Arnhoff, "Social Consequences of Policy Toward Mental Illness," p. 1278.
- ⁴²Jonathan F. Borus, "Deinstitutionalization of the Chronically Mentally Ill," New England Journal of Medicine 305 (August 6, 1981), pp. 341-342.

V. THE TRANSFORMATION OF

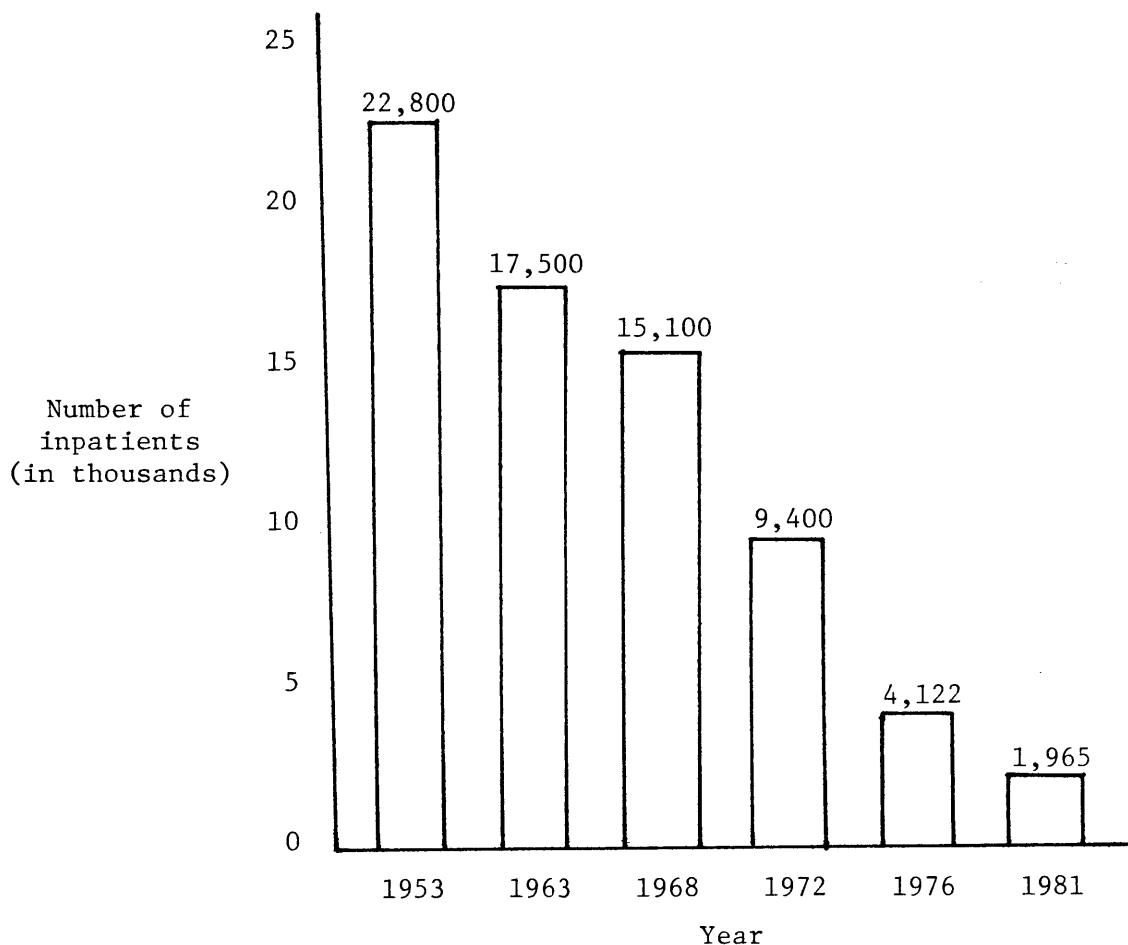
PUBLIC MENTAL HEALTH SERVICE PROVISION IN MASSACHUSETTS SINCE 1950

In order to appreciate the extent to which the depopulation of institutions had been motivated by many forces -- fiscal pressures, technological change, changing social policy and court decisions -- it is necessary to examine how an individual state transformed its mental health system. The policy decisions regarding the specifics of mental health care provision are, after all, made at the state level, so it is at this level where the many forces affecting mental health care come together. This chapter therefore reviews the history of public mental health care in one state, Massachusetts, over the past thirty years.

Massachusetts is a good state in which to examine the process through which the pattern of public mental health services has changed, because it was one of the first states to begin depopulating its institutions. The number of residents in Massachusetts state hospitals had decreased from a peak of 22,798 in 1953 to 1,965 in 1981 (see Figure 5). Three state hospitals have been closed since 1973, leaving eight.

More recently, the Massachusetts Department of Mental Health (DMH) has been rapidly developing community based mental health services. In FY 1976, DMH spent 34% of its budget providing community based services. By FY 1981, this percentage had increased to more than 65% of a budget almost twice as large.^{1,2} The transformation led the Washington Post to report in 1980 that "Massachusetts is now the best hope of mental health reformers."³

Figure 5. Number of Residents in State Mental Hospitals, Massachusetts, 1953-1981.



Sources: Carl A. Taube, "State Trends in Resident Patients -- State and County Mental Hospital Inpatient Services 1967-1973," Statistical Note No. 113 (Rockville, Md.: National Institute of Mental Health, 1975), p. 7; U.S. General Accounting Office, Returning The Mentally Disabled To The Community: Government Needs To Do More (Washington, D.C.: Government Printing Office, 1977), p. 9; Michael J. Witkin, "Provisional Patient Movement and Selective Administrative Data, Inpatient Services by State, United States 1976," Statistical Note No. 153 (Rockville, Md.: National Institute of Mental Health, Biometry Branch, 1979), p. 25; Massachusetts Senate, Ways and Means Committee, Budget Recommendations: Fiscal Year 1981 (Boston: 1980, p. 21-1; Massachusetts Senate Ways and Means Committee, Budget Recommendations: Fiscal Year 1982 (Boston: 1981), p. 21-1.

If one attempts to interpret the transformation of mental health care in Massachusetts simply as an implementation of the deinstitutionalization idea, it is difficult to understand why the first meaningful development of transitional community residences lagged twenty years behind the beginning of the trend to depopulate state institutions. When the individual effects of the forces acting upon the state are examined, however, the lag is easily understood. The initial depopulation was motivated by the overcrowding in the underfinanced institutions and facilitated by the introduction of psychoactive drugs. The state was not compelled to create community residences until the courts required it in the 1970s.

Depopulation of institutions began with changing administrative policies in state institutions in the early 1950s. Worcester State Hospital was one of the first institutions in the United States to experience a decline in its resident population, with the number of residents decreasing from 2,858 in 1950 to 2,693 in 1955.⁴ This was a period in which the idea of community mental health was beginning to rise in popularity, but Morrissey and Goldman suggest that much of the change in policy can be explained by the fiscal pressures on the hospital. They write that the hospital superintendent's

plan to reduce the hospital's census was based on pragmatic considerations. Staff shortages and overcrowded wards made reduction of the chronic caseload the only way the hospital could begin to offer a semblance of humane care and active treatment . . . In a short time . . . it became clear that the climate of opinion in the community was becoming more tolerant [toward mentally ill people living in the community]. The initial successes fueled the zeal of the staff and the release program was stepped up as fast as family and other placements could be found.⁵

State hospital censuses were soon dropping across the state, but the extent to which released patients benefitted from the policy is open to debate. There were certainly very few community mental health services in existence during this period. On the other hand, many of the released persons were probably inappropriately institutionalized to begin with. The state hospitals were, after all, service providers of the last resort, taking in people who had diverse problems. As Morrissey and Goldman put it for Worcester State, "The hospital had assumed responsibility for the residual welfare and psychiatric needs of the community."⁶ Thus, it may well be that relatively few of the individuals discharged during the 1950s required community services. The obvious benefit of the depopulation, however, accrued to the acute mental patients who received better service when the hospitals ridded themselves of the burden of caring for chronic patients. It was also during this period that psychoactive drugs gave psychiatrists the power to control the disruptive behavior of patients. Consequently, it can be argued that, for the first time in a century, the hospitals were again able to treat some of these acutely ill individuals quickly and send them back to the community before their condition deteriorated in the institutional environment.

The first real impetus for the development of community-based services only came in 1963, with the passage of the federal CMHC legislation. The federal legislation had two interrelated effects on Massachusetts: first, it stimulated statewide mental health planning and thereby precipitated a reorganization of DMH; and, second, it encouraged the use of the CMHC as a locus of treatment.

With the federal funds which were available for comprehensive mental health planning, the state created the Massachusetts Mental Health Planning Project. The project produced a report entitled Mental Health for Massachusetts in 1965.⁷ Acting on the recommendations in the report, the Massachusetts legislature passed the Comprehensive Mental Health and Retardation Act of 1966, Chapter 735 of the Massachusetts General Laws.

The federal provisions for the construction of CMHCs, however, bypassed the state level of government, leaving open the possibility that local governments and private organizations could request funds. State officials obviously wished to incorporate any new facilities into the DMH system, however, as evidenced by the provisions of the 1966 Massachusetts law. The primary effect of the 1966 law was to divide Massachusetts into 37 catchment areas for the provision of mental health services. This was a strong reflection of the federal preoccupation with the CMHC, in that it was assumed in the federal legislation that each CMHC would serve such a catchment area. Thus, the state legislation's primary importance was to create the administrative changes -- the creation of area citizen boards, provision for the appointment of area directors, grouping of the areas into administrative regions -- which would permit the state to capitalize on the availability of federal funds for CMHCs. It is not that the Planning project ignored the need for community services other than CMHCs -- Mental Health for Massachusetts mentions, for example, ex-patient clubs, halfway houses and aftercare clinics -- but the report seems to suggest that a community-based mental health service system is essentially a system of CMHCs.

Whether the Planning Project actually believed that mental health care in Massachusetts would be transformed completely through the construction of CMHCs or whether the emphasis on CMHCs was simply a consequence of the availability of federal funding, the number of CMHCs in Massachusetts increased from 2 in 1967 to 15 in 1972.⁸ Given that CMHCs are a very expensive proposition, this growth dwarfs the importance of growth in other types of community programs over that same period. Indeed, former DMH commissioner Robert Okin describes the effect of the Massachusetts legislation on the growth of community programs as rather insignificant:

While [the] legislation set forth the framework for the development of a community based delivery system, nothing in this Act guaranteed the community services it described so eloquently. Nothing in [the] statute committed significant resources to establish community services. The statute enabled. It did not commit. It was a statement of intent, not action. The result was that for years after its enactment, with some exceptions, there was only infinitesimal movement in our state to develop a network of community-based services.⁹

In fact, the growth in the number of CMHCs may represent a game of semantics. Among the first CMHCs to be created in Massachusetts were none other than the same state hospitals which the CMHC legislation was intended to replace. The logic of such conversions was that each hospital was located in an area which would require a CMHC anyway. If the hospitals were going to be phased down, why not take a part of each one and make it into a CMHC? Of course, the hospitals were in such poor physical condition that any funds that could be had to upgrade them were certainly welcome.

A similar logic was used to create other CMHCs as well. For example, the Massachusetts Mental Health Center, which had long functioned as the teaching mental health clinic of Harvard Medical School, was one of the first Massachusetts CMHCs. Similarly, psychiatric units in community

general hospitals were converted to CMHCs.¹⁰

Whether these new CMHCs served the population discharged from the state hospitals is yet another question. The then commissioner of DMH, Milton Greenblatt, writes that, during the period 1967-1972,

The overall number of patients cared for in the system rose dramatically as the result of the multiplication of community facilities, from approximately 25,000 per year to well over 70,000 per year.¹¹

Given the poor reputation of CMHCs nationally in serving the needs of the indigent mentally disabled, however, and knowing that Massachusetts Mental Health Center, for example, has traditionally served an affluent population, it appears likely that many of the newly served clients were not necessarily the most needy.

Nevertheless, during this period the number of institutionalized mentally disabled continued to decline. Where, then, did the released individuals go? It appears that, in Massachusetts as elsewhere, the availability of federal Medicaid funds prompted hospital superintendents to discharge their residents to nursing homes.¹² One study

of a 10 percent sample of patients discharged from Boston State Hospital to the community over a three-year period [1965-1968] revealed that a little more than half were discharged to supervised residential facilities (mostly nursing and rest homes), while a little less than half were discharged to independent living arrangements (with families or alone) or to a semi-independent setting (foster or day care). Whether a patient was likely to be discharged to independent living or to a nursing or rest home related especially to two factors: age and length of stay in the hospital. Significantly more patients below age 60 returned to independent or semi-independent living. Those who had been in the institution for more than five years were more likely to be discharged to a supervised residential setting. Younger, more recently hospitalized individuals had the best chance of resuming community living while older, longer staying people were frequently transferred to nursing or rest homes.¹³

The use of nursing homes continued through the 1970s. In 1978, of 48,314

residents in Massachusetts nursing and rest homes, 3,676 (7,6%) had been admitted directly from a state mental hospital. An additional 11,731 (24.3%) of the residents were mentally ill, were mentally retarded and/or had behavior problems. The mentally disabled tended, moreover, to be concentrated in the homes providing relatively low levels of care.¹⁴

The use of nursing homes has already been questioned above, insofar as the nursing home environment can be considered as institutional as a state hospital or state school environment. The U.S. General Accounting Office, however, goes farther than merely suggesting that an inordinate number of mentally disabled individuals have been placed in nursing homes. The Office provides statistics that show that a large number of residents of Massachusetts institutions have become concentrated in some of the worst nursing homes in the state. Moreover, a Massachusetts official told the Office

that there was a general tendency to place formerly institutionalized persons in those nursing homes where the quality of care was poorer and safety standards not complied with as rigidly as in other nursing homes. He said that, generally speaking, the more ex-mental patients there were in a facility, the worse the conditions.¹⁵

Returning to the late 1960s, however, the administration of DMH was not at all organized in a manner that would permit it to deal with the needs of discharged patients. Area director positions went unfilled. Where there were administrators fulfilling area director functions, their responsibilities were limited to overseeing a system of community services which hardly existed. Responsibility for institutionalized persons rested with superintendents of hospitals which served an entire region (made up of several areas). Thus, once a person left an institution, responsibility for the care of that person shifted from a hospital superintendent to

an area administrator. The DMH administration saw the insitutional-community division of responsibility as a problem in providing the continuity of care needed by clients and sought to improve the situation through the introduction of unitization.

"Unitization" referred to the separation of each regional hospital into units serving the clients from each respective area in the region. The area director would be responsible for all services provided to people from his/her area, including the services provided within the area unit in the hospital. According to David Myerson, superintendent of Worcester State Hospital during its unitization in 1970, the administrative change did not significantly alter the operation of the hospital,¹⁶ although it can perhaps be argued that the change was required for the later development of community programs to be feasible.

The development of community-based programs was still not a realistic possibility, however, because too much of the state's resources were tied up in maintaining the institutional system. Myerson describes the dilemma:

[S]hould the Steward request \$50.000 from the legislature to prepare a leaking roof, or for more social workers, or for funds to purchase a community-based residence? As long as patients reside in the hospital, the leaking roof must be repaired. Given the severely limited budget, as well as inflation, it was difficult to pry money from the [Worcester State Hospital] budget to establish community programs. The care of the building locked even progressive administrators into perpetuating this old institutional system.¹⁷

Many of the institution's expenses were indivisible, so that the decreases in institutional censuses did not produce proportionate savings. For example, the costs of maintaining the grounds of an institution remained constant regardless of the number of residents there. It was becoming increasingly clear that monetary savings from decreasing institutional

populations would be realized only if some institutions could be closed down entirely.

In spite of the hospital's policy of early discharge of patients, the number of people in institutions would not fall as quickly as the administrators hoped. This was due in large measure to the fact that, irrespective of the changes in treatment philosophy within the mental health field, the general community still regarded the mental institution as a place of last resort to send socially undesirable people. Myerson writes that he

soon learned that, as Superintendent, I was expected to follow the tradition of all my predecessors, namely to accept any mentally ill or even socially incapacitated person whose admission was requested by any community agency. An old man, for example, might break his hip and be hospitalized for his surgical procedures in one of the local general hospitals. Following the surgical procedure, he would need a long convalescence; but local nursing home beds were unavailable. If he exhibited confusion or disturbing behavior patterns during his postoperative care, the administrator of the local general hospital could charge him with a minor violation (like disturbing the peace). Two psychiatrists, not connected with [Worcester State Hospital], could then recommend to the district court judge that the patient be sent to [Worcester State] on a 30-day commitment. As a rule, the judge followed this recommendation and ordered the old patient transferred to [Worcester State]. Since this procedure only happened to older men and women without families and money, this 30-day observation was, in effect, a permanent commitment to the state hospital, for at that time there was no other place to send them. I once complained to the district court judge, who condoned this transfer on the basis that it cost four times as much to hold the old person in a general hospital than it did in the state hospital

It was not unusual for physicians from general hospitals to refer patients even from Intensive Care Units if they were obstreperous or assaultive. The fact that the state hospital had limited medical facilities was never raised as an issue. . . .

The district courts, too, believed that the state hospital was mandated to accept whomever the judge decided to send. Consequently, [Worcester State] received arsonists, exhibitionists, alcoholics, and drug users, as well as psychotic people who were detained by the police¹⁸

This situation changed somewhat in 1971, when the state Mental Health Reform Act went into effect. The act was similar to many laws passed in other states during the same time period in order to limit the states' ability to involuntarily commit individuals to mental institutions. States needed to pass such laws for fear that federal courts would find existing commitment statutes unconstitutionally vague. One of the most important effects of the law, however, was to give superintendents the power to limit admissions to hospitals.

The revised statutes encouraged voluntary admission and prohibited involuntary admission to the hospital except when patients were proven to be physically dangerous to themselves or to others. Only a qualified physician was allowed to determine this degree of dangerousness and mandate an admission to the hospital. One of the crucial features of this law was that it gave the Superintendent the authority to determine who would be accepted as a qualified physician and to withdraw this privilege if the community physician made inappropriate referrals. For the first time, the Superintendent had some authority to control admissions. The law even made psychiatric screening necessary before a judge could mandate the admission of a patient from his court.

This law helped the state hospital administration. At least the general hospital and other community agencies could no longer commit at will the nuisances, the harmless senile people, or the obstreperous alcoholics.¹⁹

The Massachusetts Mental Health Hospital Planning Project concluded that the act was

more directly responsible than any other factor for the accelerated census decline evident in our state hospitals during [the years 1971-1973]. . . . The legislation has strikingly decreased the proportion of involuntary admissions to our state hospitals. In 1970 such admissions represented 76 percent of the cases opened in institutions; in the Act's first 12 months (effective date November 1, 1971), the proportion of involuntary admissions was down to 27 percent. Prolonged involuntary civil commitments were down from 811 in fiscal year 1971 to 325 in the first 12 months after [the legislation] became effective.

Not only has there been a shift in the proportion of involuntary to voluntary commitments, the Reform Act also has tended to reduce the absolute number of admissions to state hospitals. Because of the

legislation's more stringent requirements for admissions, mental health personnel throughout the state have demonstrated an increasing reluctance to admit patients, even on a voluntary basis, unless there are compelling reasons to do so. There also has been a 50% reduction in the number of pre-trial court commitments to mental hospitals as a consequence of the 1970 Act. The number of such admissions dropped from 1,888 in fiscal year 1971 to 944 in [the law's] first year since many more pre-trial psychiatric evaluations are now performed in the district court clinics operated by the Department of Mental Health.²⁰

As the number of institutionalized individuals continued to drop, it finally became feasible for DMH to begin to close institutions, which it did, beginning with Grafton State Hospital in 1973. By this time, the incentive to close institutions was even greater, because a number of factors were threatening to make the costs of institutionalization skyrocket at an unprecedented rate.

In part, costs were increasing because of the deinstitutionalization process itself. As the institutions rid themselves of the residents who appeared most likely to be able to function successfully in the community, they were unavoidably left with the residents who required the most attention and, consequently, the most resources. In addition, the institutions had traditionally relied on the labor of residents to help run the institutions. With the most productive of these residents now in the community, institutional employees had to do more themselves. Moreover, there was pressure not to use any residents for work at the institutions unless that work was clearly therapeutic, and even then only if those residents were paid wages. DMH was therefore unable to lay off employees as institutional populations decreased. The consequence of this was that the per patient costs of institutional care rose rapidly and the total costs of operating any given institution did not drop.

The incentive of 50% federal reimbursement under Medicaid encouraged DMH to invest heavily in the physical upgrading of institutions. Between FY 1970 and FY 1980, the annual cost of caring for a client at Worcester State Hospital increased from \$8,909 to \$31,900; at Danvers State Hospital the increase was from \$4,951 to \$37,802. During the same period, federal reimbursement under Medicaid increased from \$1,475,306 to \$82,576,521, although much of this went to state schools for the retarded.²¹

Another force pushing up the cost of institutional care was the threat of lawsuits. DMH was first subjected to litigation in its provision of mentally retardation services, when a lawsuit, Ricci v Greenblatt, was filed on behalf of Belchertown State School residents. The suit alleged that the constitutional rights of the mentally retarded citizens of the school were being violated because the school was an unhealthy, unsafe living environment. The state entered into a consent decree with the plaintiffs. This obliged the state to substantially improve conditions at the school. The immediate effect of the consent decree was to commit the state to an expensive, long-term upgrading of the Belchertown State School under the scrutiny of the court. The ultimate effect of the decree was much greater, however, because the success of the plaintiffs in the first action encouraged advocates to file suits against four more state schools, with each suit leading to another consent decree. The later decrees dealt not only with the quality of institutional care, but also with the rights of residents to receive care in less restrictive settings. When the court identified the low quality and high turnover of staff as a problem in providing adequate care to residents of the school, the state also entered into a personnel decree in 1978. The personnel decree covered

all five of the schools and resulted, among other things, in the upgrading of the salaries of direct care staff in the schools.²²

Thus, there were a number of important factors prompting the state to invest heavily in institutional care for the mentally disabled. It would be wrong, however, to equate this observation with the conclusion that the state became, as a consequence of putting more resources in its institutions, any more positively disposed toward institutional care of the mentally ill. If anything, the reverse was true. Compliance with federal standards, for example, required not only the upgrading of physical facilities in institutions, but also larger programmatic expenditures to care for the institutionalized. Even when institutions were certified for Medicaid reimbursement, it was still cheaper for the state to care for a Medicaid eligible client in a Medicaid reimbursable nursing home than in a state institution.

This became doubly true with the advent of the consent decrees. Greenblatt's description of the state administration's thought process in response to the filing of Ricci v. Greenblatt is instructive:

[A] highly significant meeting between the governor's staff, representatives of the human services secretariat, and mental health administrators took place. . . .After much debate, it appeared the effective choices were defined: (1) a program that would upgrade both treatment programs and physical plants as soon as possible for all residents in the schools, while continuing to develop community alternatives for those who did not belong in institutions or (2) a slow but vigorous four- to five-year effort concentrated entirely on reducing population through community placements. In the second plan, by holding institutional staff complements constant, within four to five years the minimal staff-patient ratios required by standard-setting agencies would be reached. As for the physical plant, the proposal was to repair only those buildings to be occupied after the four- to five-year period of population reduction. Everything would be neglected, save emergency repairs and renovations in any other buildings used during the reduction period.

In making this hard choice -- one that faces any state with limited resources and that will eventually face the whole nation -- the second alternative was favored, namely, to invest in community alternatives essentially and, by expanding community resources, to depopulate the institutions as fast as possible. Much as it might be regretted, the governor ruled that the state could not afford to do everything. It could not renovate plants, add needed personnel, and create new community alternatives all at the same time. Thus, in this very hard decision, it was clear that literally thousands of persons in our state institutions would continue for many more months to receive the kind of care and treatment that everyone agreed was far from humane. One could take little solace in the fact that this situation would be gradually resolved over four to five years. It was a sad victory of fiscal realities over human needs.²³

As it turned out, a new judge was assigned to the case after this meeting and took a harder line. The state administration was consequently compelled by the decree to invest heavily in upgrading institutional services as well as expanding community services.²⁴ The consent decree therefore had the effect of making the DMH budget grow more quickly than it otherwise would have. Indeed, there were probably many people within the DMH administration who saw the decree as a blessing, compelling legislators to appropriate to the department funds which they would have preferred not to spend at all.

The expansion of the DMH budget was stopped with a vengeance, however, in 1975, when Michael Dukakis, who was then governor of Massachusetts, froze \$26 million of already appropriated human services funds. New community programs were started up late or not at all, while the state schools and hospitals were unable to fill staff vacancies. Given the high rate of turnover in the underpaid mental health aide positions, staffing levels in the institutions fell rapidly. Conditions in the institutions worsened noticeably. In particular, overworked direct

care staff in the institutions relied increasingly on seclusion and restraint of residents in order to maintain order in the institutions.²⁵

Conditions in the mental health system began to change only after the freeze was lifted. At this point, the impetus for expansion came again from a lawsuit, with yet another consent decree, this time concerning Northampton State Hospital. The Northampton decree addressed the rights of the mentally ill to be treated in the "least restrictive environment." Under the decree the state consented to providing services to mentally ill persons in community residence programs not as confining as state hospitals wherever feasible. The decree also specified the quality of community services to be provided, thereby preventing "dumping" of patients into programs of no therapeutic value. As a result, the decree did not require major upgrading of the facilities at the hospital. The decree did, however, require the establishment of a comprehensive system of mental health care in the community. Thus, DMH was finally propelled, willingly or unwillingly, into a major expansion of community-based services to the mentally ill. A major portion of the expansion occurred, naturally, in Region I, in the westernmost part of the state -- the region served by Northampton State. The consent decree was signed in 1978. In FY 1979, the region spent \$6,534,000 purchasing community-based services by contracts. By FY 1981, that amount had tripled, to \$21,505,000.²⁶ Indeed, it is clear that the courts had an enormous effect on the region's budget, as Belchertown State School was the regional state school. Under the influence of both decrees, the total regional budget increased from \$11,711,026 in FY 1975 to \$28,378,606 in FY 1981.²⁷

The lesson of the decree was not lost on the state administration. If the legislature wished to retain any control whatsoever over the DMH system, it was imperative that the most egregious problems with the system be eliminated before yet another action was brought against the state. DMH therefore moved quickly to create community-based programs not only in Region I, but across the entire state. In FY 1976, DMH spent 34% of its budget on community programs. In FY 1981, it spent 65% of its budget on such programs.²⁸ Moreover, the FY 1981 DMH budget appropriation of \$438,373,174 was twice the amount of the FY 1976 appropriation.²⁹

It is significant, too, that much of this expansion of community-based services occurred via the purchase-of-service mechanism. Only in Region V, in southeastern Massachusetts, is DMH heavily involved in direct provision of community-based services. In all other DMH regions, administrators rely on private vendors. DMH expenditures on purchase-of-service have increased from \$5.5 million in FY 1975 to more than \$127 million in FY 1981. DMH now has approximately 2,000 contracts with about 500 providers.³⁰ The financial statistics understate the reliance of the state on private vendors, because the state subsidizes them by placing state employees in the private programs as an in-kind contribution. The effect of the expansion of the purchase-of-service system has been to create a powerful, new interest pushing for the expansion of community services. It is therefore important to consider how the system developed.

DMH first began to rely on the contract mechanism in the provision of mental retardation services. Associations for Retarded

Citizens (ARCs), which are voluntary organizations made up largely of parents of retarded children, originally came into existence to fill a need not being filled by the state. The ARCs set up community programs for the retarded at a time when the state did not have such programs and when the state schools had already adopted highly restrictive admissions policies. When DMH, under pressure to depopulate its institutions, particularly after the filing of the Belchertown suit, decided to get into the provision of community-based services for the retarded itself, it found it easier to contract with ARCs and rely on their expertise than to develop that expertise itself.

In many instances, however, DMH wished to develop programs which no organization was providing. In these cases, the DMH administration simply felt that the programs would be too difficult to develop using state employees. Former DMH commissioner Robert Okin has said that the rules which govern direct state provision of services "would drive any business into bankruptcy." He lists specifically the constraints of the state item budget process, civil service and collective bargaining.³¹

While these problems may have been seen as real obstacles, they probably would have appeared less significant had DMH not been in such a rush to deinstitutionalize. With the Northampton suit filed, however, the rapid development of community programs became a high priority. The shift to purchase-of-service contracting was therefore exceptionally rapid. As the Massachusetts Taxpayers Foundation puts it:

State agencies backed into large-scale purchase of service. These agencies did not have the structural capacity to establish standards and expectations for programs, much less to monitor and evaluate them. Purchase became important, almost overnight, without any planning.³²

The Foundation attributes the use of private vendors in part to an "inferiority complex" within state government:

State agencies turned to the provider community to run their programs in large measure because of the state's failure to run institutions that offered more than custodial care and programs that rendered treatment intervention to clients. This inferiority complex persists today.³³

It is, in fact, true that Commissioner Okin believed that

It simply makes no sense at all for us to perpetuate a publicly operated system which guarantees inferior care to many of the State's mentally ill citizens. The public sector should not continue to do what the private sector, if given the right kind of support, could do much better and more efficiently.

Okin's attitude , however, was in large measure simply a recognition of the fact that a two-class system of mental health care exists, in which the state provides the lower quality class of services to those individuals unable to afford higher quality private psychiatric services. Okin claimed he wished to provide all psychiatric services through the private system which currently serves only the affluent.³⁵

Whether Okin actually believed that the two-tier system of care could be transformed into one unified system of care is open to debate. However, as the Massachusetts Taxpayers Foundation points out, the development of a purchase-of-service system was a pragmatic approach to expanding the mental health system during a period in which "fiscal crisis" was an increasingly important issue in Massachusetts:

the desire to limit or reduce public payrolls has encouraged the growth of purchase of services. Faced with Governor Dukakis' attrition program, state officials viewed contracting with private vendors as a strategy to improve the administration as well as the delivery of services without adding to the permanent payroll.³⁶

DMH appropriations in the state budget increased substantially during the period Okin was expanding the purchase-of-service system,

from \$276 million in FY 1978 to \$438 million in FY 1981.³⁷ By this point, the DMH administration clearly saw expansion of its service system as a major goal and, as a consequence, aggressively sought ways to increase its revenues. For example, DMH would start new programs more slowly than projected in its annual budget request and would then "over-annualize." For example, DMH would request, say, \$100,000 to purchase a new community program, with the understanding that the program would commence operations half-way through the fiscal year. It was understood that the appropriation for the same program would be annualized in the DMH budget request for the following fiscal year, so that instead of requesting only \$100,000 for the program, DMH would request \$200,000. This recognized the fact that the original appropriation was sufficient only to cover half a year of operation. In the first year, however, the program would not actually begin to operate until the fiscal year was, say, three-quarters done. DMH would see to it, however, that in that quarter of a year the program would spend its entire first year appropriation, so that the following year DMH would request \$400,000 for the program. In the meantime, however, residents of state institutions which DMH had claimed would be served by the new community program would remain institutionalized for an additional three months. DMH would then ask for deficiency funds to cover the unanticipated costs of caring for those residents for that period of time. Once a new program was started, however, DMH would not release funds intended to upgrade the program, using the funds instead to start up other new programs. Programs which benefitted financially from the over-annualization were often expected to hire, as part of their contracts, employees who actually

performed the tasks of DMH administrators.³⁸

The use of such techniques, combined with the effect of the consent decrees, has served to greatly expand the DMH service system. Interestingly, the change in the style of DMH, prompted perhaps by the decrees, has probably done more to transform public mental health services in Massachusetts than any of the highly publicized earlier initiatives to deinstitutionalize the mentally ill. In creating a powerful group of service providers, DMH has created an external force which will create the pressure on the state administration necessary to effect future improvements in public mental health services.

On the other hand, by creating a massive purchase-of-service system on which it is dependent, DMH has sacrificed much of the control which it could have had over the state mental health system. DMH is neither administratively organized to monitor vendors, nor is it willing to threaten them with sanctions should it find services they provide inadequate. Vendors are in effect accountable only to themselves.

Meanwhile, there are still major questions about the quality of services being provided to DMH clients. A Special Committee of the Massachusetts Senate concluded in 1980 that although

community-based care is preferable to treatment provided in a hospital setting in almost every case, the current DMH program of deinstitutionalization contains serious flaws. Claims of success by state officials have often been inaccurate and misleading.

. . . [I]nsufficient community resources now exist for successful deinstitutionalization. In too many cases, there has been poor planning for the needs of both communities and patients. Financial management and staffing, in particular, have been inadequate.

As a result the quality of care in many community programs is poor. Many former mental hospital patients are released to the

community without any after-care or are merely transferred to small institutions such as nursing homes instead of being integrated into proper community settings. The non-affluent person who must depend on DMH still receives inferior care in the community after being discharged from a state hospital.³⁹

Moreover, with the passage of Proposition 2-1/2 in Massachusetts, the pressure on state government to reduce expenditures has again increased. The legislature, perturbed not only by the rapid growth of the DMH budget but by the lack of accountability of DMH officials to legislators, granted DMH a FY 1982 appropriation with no funds for new community programs and no funds for the regional level of the DMH bureaucracy.⁴⁰ It may well be, then, that the aggressive policies of DMH in the past few years will ultimately backfire on the department administration.

Footnotes

- ¹Natalie Ammarell, Final Report: Worcester State Hospital Study (Waltham, Mass.: University Health Policy Consortium, 1981), p. 2.
- ²Massachusetts Senate, Ways and Means Committee, Budget Recommendations: Fiscal Year 1982 (Boston: 1981), p. 21-7.
- ³Philip J. Hiltz, "Mental Care Revolution: Clearing 'Warehouses,'" Washington Post, October 27, 1980, p. A2.
- ⁴Joseph P. Morrissey and Howard H. Goldman, "The Ambiguous Legacy: 1856-1968," in The Enduring Asylum: Cycles of Institutional Reform at Worcester State Hospital, eds. Joseph P. Morrissey, Howard H. Goldman, and Lorraine V. Klerman (New York: Grune and Stratton, 1980), pp. 86-87.
- ⁵Morrissey and Goldman, "The Ambiguous Legacy," pp. 87-89.
- ⁶Morrissey and Goldman, "The Ambiguous Legacy," p. 91.
- ⁷Massachusetts Mental Health Planning Project, Mental Health for Massachusetts (Boston: Massachusetts Mental Health Planning Project, 1965).
- ⁸Milton Greenblatt, Psychopolitics (New York: Grune and Stratton, 1978), p. 117.
- ⁹Robert L. Okin, "Public/Private Collaboration on Behalf of the Mentally Ill" (1980), p. 10.
- ¹⁰Greenblatt, Psychopolitics, pp. 141-156.
- ¹¹Greenblatt, Psychopolitics, p. 117.
- ¹²See, for example, Morrissey and Goldman, "The Ambiguous Legacy," p. 87.
- ¹³Massachusetts Mental Hospital Planning Project, Community Mental Health and the Mental Hospital (Boston: United Community Planning Corporation, 1973), p. 33.
- ¹⁴Massachusetts Office of State Health Planning, "Massachusetts Nursing and Rest Home Patients" (1978).
- ¹⁵U.S. General Accounting Office, Returning The Mentally Disabled To The Community: Government Needs To Do More (Washington, D.C.: Government Printing Office, 1977), pp. 13-14.
- ¹⁶David J. Myerson, "Deinstitutionalization and Decentralization: 1969-1977," in The Enduring Asylum, eds. Morrissey, Goldman and Klerman (New York: Grune and Stratton, 1980), p. 114.

- 17 Myerson, "Deinstitutionalization and Decentralization," p. 105.
- 18 Myerson, "Deinstitutionalization and Decentralization," pp. 107-108.
- 19 Myerson, "Deinstitutionalization and Decentralization," p. 108.
- 20 Massachusetts Mental Hospital Planning Project, Community Mental Health and the Mental Hospital, p. 14.
- 21 Massachusetts Senate, Ways and Means Committee, Budget Recommendations, p. 21-8.
- 22 Massachusetts Senate, Ways and Means Committee, Budget Recommendations, pp. 21-7 - 21-8.
- 23 Greenblatt, Psychopolitics, p. 77.
- 24 Greenblatt, Psychopolitics, p. 79.
- 25 Massachusetts Advocacy Center, Frozen Means You Don't Move: The Impact of Budget Cuts on People in Massachusetts Institutions (Boston: Massachusetts Advocacy Center, 1978).
- 26 Massachusetts Senate, Ways and Means Committee, Budget Recommendations, p. 21-24.
- 27 Massachusetts Senate, Ways and Means Committee, Budget Recommendations, p. 21-23.
- 28 Ammarell, Worcester State Hospital Study, p. 2.
- 29 Massachusetts Senate, Ways and Means Committee, Budget Recommendations, p. 21-7.
- 30 Massachusetts Senate, Ways and Means Committee, Budget Recommendations, p. 21-15.
- 31 Okin, "Public/Private Collaboration," p. 7.
- 32 Massachusetts Taxpayers Foundation, Purchase of Service: Can State Government Gain Control? (Boston: Massachusetts Taxpayers Foundation, 1980), p. 32.
- 33 Massachusetts Taxpayers Foundation, Purchase of Service, p. 19.
- 34 Okin, "Public/Private Collaboration," p. 9.
- 35 Okin, "Public/Private Collaboration," p. 6.
- 36 Massachusetts Taxpayers Foundation, Purchase of Service, p. 36.

³⁷Massachusetts Senate, Ways and Means Committee, Budget Recommendations, p. 21-7.

³⁸Massachusetts Senate, Ways and Means Committee, Budget Recommendations, pp. 21-7, 21-24 - 21-25.

³⁹Massachusetts Senate, Special Committee to Investigate Seclusion, Restraint and Deaths in State Supported Facilities, Interim Report, pp. x-xi.

⁴⁰Jean Dietz, "Mental health officials say cuts will do damage," Boston Globe, August 30, 1981, p. 40.

VI. CONCLUSIONS

In recent years, "deinstitutionalization" has been a much remarked upon phenomenon. The feature of deinstitutionalization which has been most conspicuous has been the depopulation of state mental hospitals. The other feature -- the development of community services -- has been more conspicuous in its absence. It might even be said that the concept of community aftercare services for discharged state hospital patients has only become entrenched as a necessary component of the ideal of deinstitutionalization in the past decade and that this has occurred largely because the need for these services has been felt so strongly in their absence.

If one then wishes to explain the enormous transformation in the delivery of public mental health services in the latter half of this century, it is obvious that the power of the idea of deinstitutionalization has not been the primary force producing change. In seeking other, more powerful agents of change, one is led to examine the forces acting upon state-level policy-makers, as it is they who make the decisions that determine which public mental health services are provided. This search proves fruitful, as it becomes clear that there have been a number of powerful forces encouraging states to depopulate their mental institutions.

The depopulation of institutions began at a time when state hospitals were approaching a state of physical decay and were filled to capacity. They simply could not absorb more patients, yet if the state of

the existing hospitals was any indication, no funds would be forthcoming to build new ones. As the general population continued to grow, however, the numbers of the mentally ill grew as well, and with every passing year the number of people being committed to mental hospitals rose. As the superintendents were powerless to control the stream of new admissions, they did all that could be expected: they began to discharge patients. They discharged their most docile chronic patients, as these would create the fewest problems in the community. They discharged acute admissions as soon as the most disturbing symptoms subsided, in the hope that perhaps these would not reoccur too quickly in the outside world.

The release of patients soon became much easier as psychoactive drugs became available. The drugs suppressed the most objectionable symptoms of the patients. If the discharged patients were provided with these drugs, perhaps they would disturb no one in the community. Within the hospital, the drugs could be used as chemical straitjackets. The institutions became much calmer environments, perhaps even permitting the traditionally custodial institutions to provide some small measure of treatment to their residents.

With the evolution of national social policy, maintenance of the mentally ill in the community also presented fewer financial problems than in the past. Before the rise of adequate and universal social benefits, few of the mentally ill could have been released from the hospital. They would have starved unless provided cash by the state, and the provision of benefits to only the mentally ill could have produced serious consequences, as it would have provided an incentive to other poor people to act mentally ill. As expanding federal benefits provided under the

Social Security Act increasingly met the needs of the poor in general, the provision of state support for the mentally ill was no longer so dangerous. Moreover, the federal government was itself beginning to assume responsibility for supporting the mentally ill, along with other needy populations.

In its desire to improve the national health care system, the federal government was also stimulating an expansion of the supply of nursing home beds. This provided the beleaguered hospital superintendents with a new opportunity to ease the pressures of overcrowding. Now there was a place to put the harmless but nevertheless burdensome chronic patients unable to care for themselves. When the federal government offered, through its newly-established Medicaid program, to assume half the costs of this care, a wide number of state policy-makers undoubtedly took notice. Nursing home operators, well aware of the presence of Medicaid and Medicare dollars, quickly provided more beds and hospital superintendents took advantage of their availability, releasing even more patients.

The size of the cash transfer payments being made under the Social Security Act was also increasing and these were soon large enough that it became profitable to maintain the disabled in board-and-care homes for the price of the transfer payments. The board-and-care homes proliferated and easily outpaced nursing homes in providing accomodation to discharged mental patients. The nursing homes beds were, in spite of the rapid growth in their numbers, always in short supply and therefore able to pick and choose the most manageable patients. Board-and-care homes, with

their inferior environments, were more often in the position of needing to take all comers, which frequently meant the mentally ill.

Unfortunately, the Social Security Act provided states with no funds to finance community residences designed to help the mentally ill and, accordingly, these were not built. The cost of operating these facilities with mostly state funds was simply too great when compared to the bargains available in nursing and boarding homes. At any rate, the public was being told that CMHCs would provide the comprehensive community care that the mentally ill outside hospitals needed. The CMHCs were indeed supposed to provide services to the traditionally hospitalized subpopulation of the mentally ill, but then CMHCs were supposed to provide everything to everyone, which in effect left them free to serve whomever they pleased. The traditionally hospitalized were the most difficult and unrewarding to serve and, consequently, became the least served.

Ironically, as the Social Security Act was encouraging the maintenance of the mentally ill in custodial community facilities, it was attempting to make therapeutic environments out of state hospitals. In presenting states with the availability of Medicaid reimbursement for persons in state hospitals, the federal government was making an offer the states could not refuse. The price to the states was substantial upgrading of institutional care. This only made the states more anxious to depopulate the hospitals, as meeting federal standards for large numbers of patients would have been prohibitively expensive. And where the federal government was merely offering states an incentive to upgrade their hospitals, in the 1970s the courts threatened to compel the states to do so. Depopulation of hospitals continued unabated.

The number of patients in state hospitals is now less than one-third of what it was twenty-five years ago. In some states, the depopulation has been especially drastic -- the number of patients in Massachusetts is now less than one-tenth of what it was in 1953. Community residences have, in the meantime, been built only sporadically. One of the few states where community residences have been developed on a meaningful scale is Massachusetts, and this was the result of a lawsuit aimed at halting the "dumping" of mental patients in the community. If this has made Massachusetts the "best hope of mental health reformers" across the country, then it is especially telling that the community services provided in Massachusetts are still considered to be woefully inadequate for meeting the needs of the mentally ill in the community.

It is belaboring the obvious to note that the change in state mental health policy was not the result of purposeful, directed policy development. State governments were subjected to a field of pressures and incentives and responded as best they could. States were largely passive actors in the transformation of policy. The impetus for change came from many different directions, often unrelated to mental health. Mental health policy was in large measure determined by the federal government's desire to move the physically handicapped from scarce hospital beds to cheaper nursing homes. It was determined by federal legislators' desire to improve the living standards of the aged and the disadvantaged. It was determined by many policies, unrelated to one another, which were enacted without consideration of their consequences for the mentally ill.

What is remarkable, then, is the consistency with which these many different forces have encouraged depopulation of state hospitals. People

speak of "deinstitutionalization" in the past tense, as if they were talking about a policy planned and implemented long ago. It is more appropriate to view deinstitutionalization as a concept to describe what has happened (if perhaps inaccurately), as an idea which has itself developed alongside the changes it describes.

In the 1950s, the deinstitutionalization idea was essentially an anti-state hospital idea. The state hospitals were horrible environments and reformers focused on their evils more than on the necessary community care alternatives. The idea developed a strong following because the closing of hospitals contained elements of both humanitarian reform and monetary savings. The need for community care alternatives was of course a concern, but the concern found its expression in the development of the CMHC concept. While the failures of the CMHC program are now obvious, it is not clear that many reformers recognized the tremendous amount of community services that would be necessary to achieve the goal of comprehensive community health care. It seems many advocates of deinstitutionalization thought the mental health problem would be solved when the institutions were empty and the CMHCs built. It was not until the 1970s that the deficiencies of the reforms in mental health were fully apparent. Of course, once this point was reached, the need for community residences and client-tracking became integral parts of the deinstitutionalization concept.

This is not to deny the positive effects of deinstitutionalization as a humanitarian movement and an impetus for improvements in mental health care. Deinstitutionalization has been a powerful idea and is clung to by much of the mental health profession. It was advocates of deinstitutiona-

lization that were responsible for the development of the CMHC program. While CMHCs have not served the traditionally hospitalized mentally ill, they have nevertheless provided valuable services to many less severely ill (but nevertheless ill) people. In Massachusetts, the lawsuits which produced the first meaningful development of community services were filed by people attempting to make the state system more closely approach the ideal embodied in the deinstitutionalization concept. The point is, simply, that policy development within state government has never been driven by the ideal of deinstitutionalization.

States have, nevertheless, been able to rely on the idea of deinstitutionalization to legitimate the changes they have made in their mental health systems. When depopulation of institutions became attractive to states for fiscal reasons, states would shamelessly justify it as the implementation of the humanitarian ideal, even when the consequence was "reinstitutionalization" of the discharged patients in nursing homes. In this regard, the role of the idea of deinstitutionalization bears striking similarities to the role of the institutionalization idea in the 19th century with its "humanitarian gloss" that lingered long after the hospitals had degenerated into custodial facilities. If deinstitutionalization had not been a popular cause when depopulation began, it is questionable whether depopulation could have progressed as far as it has.

With all the problems which have resulted from the changes in mental health policy, it is, after all, difficult to argue that the outcomes have, on balance, been less desirable than could have been expected if the traditional institutional pattern of care had remained intact. Perhaps the

strongest criticism which can be made is that the elderly chronically ill have been shovelled off to nursing homes to live there until they die. It is not clear, though, that their situation would be much better in a state hospital. While the younger chronic and revolving-door populations in board-and-care home settings often live in poor conditions, hospital conditions can be equally as bad. Moreover, many of these patients undoubtedly value their liberty outside the hospital over the comforts a hospital might provide. A large number of the mentally ill are now cared for in family homes, but this has always been the case. The quality of care depends upon the family. Although the costs to the family of caring for a mentally ill member are great, they are often willingly assumed.

Framing the issue in terms of deinstitutionalization versus institutionalization obscures the more fundamental issue of what quality care is received by the mentally ill. The pioneers of institutional care in the 19th century proved that institutions can be effective treatment settings for the mentally ill. The same has been proven for community care with many successful demonstration projects. In the past thirty years, however, institutional care has been assumed to always be ineffective and inhumane, while community-based care has more often been judged against the standard of an ideal therapeutic setting.

Nevertheless, it is increasingly being recognized that hospitals have a role to play in a comprehensive system of mental health care, if only because it is unfeasible to construct many small secure facilities in the community. If the mentally ill are to be rehabilitated to the limits of their capacities, however, there is clearly an important role for many different community-based services. There is a role for transitional

community residences, to help chronic patients adjust to a more normal lifestyle. There is a role for readily available outpatient services, both for the revolving-door population and for the chronically ill who live independently. There is a role for active client-tracking, to ensure that the mentally ill are not lost "through the cracks" between community services. A comprehensive mental health care system would, unfortunately, cost many times what the most costly hospital system ever cost. Knowing that depopulation of institutions has been motivated largely by the desire to decrease mental health expenditures, it seems highly unlikely that such a system will develop in the foreseeable future.

For more than a century, society has proven unwilling to commit sufficiently large amounts of resources to provide the mentally ill with much beyond custodial care. This is somewhat understandable -- the mentally ill are a group with which most people have very little contact and with which the general public must find it difficult to identify. Perhaps the existence of an idea such as deinstitutionalization is necessary to reassure the general public that something good is being done to help these unfortunates, so that government may go about its business of dealing with these people pragmatically without risking loss of public confidence. A group such as the mentally ill (and especially the indigent mentally ill) is clearly one of the groups in society which is least able to pursue and protect its own interests in the political arena. It is a group which public administrators and politicians can claim they are serving effectively with little fear of contradiction from the group itself.

It may be sad, but it appears that it is true, that the brightest hope for improvement in the lot of the mentally ill lies in those areas

where improvement of the public mental health system serves the interests of other groups in society. Where the amount of services provided is concerned, the strongest push for expansion will probably come from the network of private service providers who have an interest in increasing their profits. Where the quality of services is concerned, the push will come from the mental health workers who themselves suffer when they must work in understaffed, underfinanced programs. Improvement is certainly not likely to come from within the ranks of the mentally disabled themselves -- they have been provided with inferior services for so many decades that if they were ever to be expected to help themselves, they would have done it long ago.

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